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Submission to the Canadian Royal Commission
on Health Services by the Government of Alberta



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ROYAL COMMISSION
ON
HEALTH SERVICES

SUBMISSION
OF
THE GOVERNMENT OF THE PROVINCE
OF ALBERTA

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JANUARY 12th, 1962

EDMONTON, ALBERTA



ROYAL COMMISSION

ON

HEALTH SERVICES

SUBMISSION

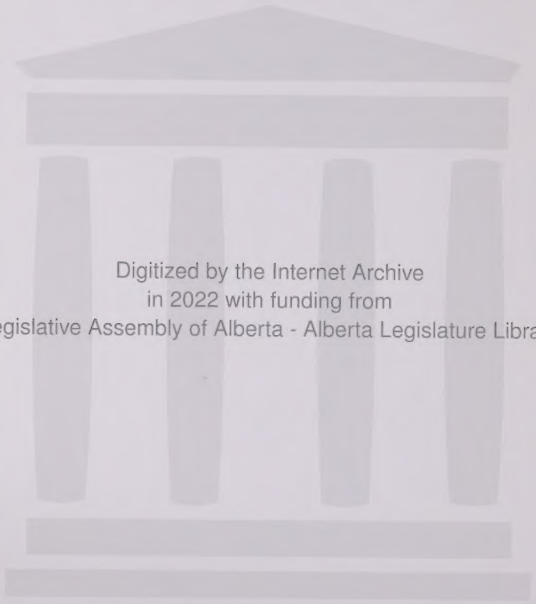
OF

THE GOVERNMENT OF THE PROVINCE

OF ALBERTA

February 12th, 1962

EDMONTON, Alberta



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Mr. Chairman, and Members of the Commission:

1. The Alberta Government welcomes this opportunity to submit for your study and consideration certain information that we trust will be of assistance to you in assessing the health services of our nation as they pertain to Alberta. We hope our submission will enable you to decide on the nature and extent of any further steps that should be considered in this field.

* 2. The Government of Alberta views with very real concern the progressive intrusion of the Federal Government into areas in which it has no constitutional right to be involved. Under The British North America Act of 1867, the responsibility of the health of the people of Canada was assigned to the jurisdiction of the provinces. Since 1948, with the introduction of federal health grants, up to the recent federal-provincial hospital plan, there has been a progressive encroachment into provincial responsibilities in the field of public health services. We do not, in any way, deny the useful nature of the financial assistance provided to the various provinces for health purposes but we hold that a far more desirable procedure and one in keeping with respect for constitutional jurisdiction would have been for the Federal Government to provide its assistance by the payment to the provinces of supplementary funds under the federal-provincial tax rental agreements which funds could then have been used by the provincial governments within their own field of jurisdiction and in such manner as they felt would be most beneficial to their people in the field of public health care. This procedure would not have involved any greater expenditure of federal funds and would, in fact, have avoided considerable cost of administration both at provincial and federal levels.

3. During the past quarter of a century in Alberta there has been a steady and progressive development of programs related to such diseases as tuberculosis, mental illness and retardation, poliomyelitis, cerebral palsy, arthritis, cancer, diabetes, rheumatic fever and pensioner medical services, etc., as will be seen as we present to you a full report of the various divisions of our public health services.

4. The basic objective of our Government's program

has been to make sure that if such services were needed they will be available to all of our citizens under circumstances which will avoid the imposition of an unduly heavy financial burden on the patient or his family. To this end, the basic principle underlying our public health program is to subsidize essential health services to the extent necessary to bring them within the financial reach of our citizens but without removing the individual's proper responsibility to pay for some reasonable part of the costs involved out of his own resources.

5. In Alberta there has been a very good reception to and utilization of the method of prepayment for medical services under Medical Services Incorporated and through the Blue Cross for supplementary hospital services over and above those paid for from public revenue under the federal-provincial hospitalization program.

6. Under the present hospitalization program as it applies in Alberta, the costs are met by payments from four sources:

1. A four mill tax on real property assessed at municipal level and which represents the municipal ratepayers' contribution to the over-all cost of the hospitalization program.
2. Direct payments from the provincial treasury of the actual hospital operating costs up to an approved ceiling, for which payments the provincial treasury is reimbursed in the amount of somewhat less than 50% by the Federal Government under the provisions of the federal-provincial hospitalization agreement.
3. A payment of co-insurance ranging up to \$2.00 per day paid for by each patient using the hospital facilities. *Certain groups of patients are exempt from this co-insurance. Paid for them by Govt. - about 2%.*
4. Additional municipal levies where such are required to make up any excess costs over the ceiling incurred in the operation of a hospital.

7. I wish to point out that the Federal Government has consistently refused to recognize the co-insurance feature of the Alberta hospitalization program as equivalent to the premiums paid by residents in those provinces using the premium systems even though

they both represent the patient contribution to the financing of the plan.

8. The Federal Government's refusal to recognize funds paid by Alberta citizens who are hospital patients in the same manner that hospital insurance premiums are recognized in other provinces constitutes, in our opinion, a gross injustice and imposes an additional financial burden on the Alberta provincial treasury.

9. In the case of a relatively small number of citizens who are financially unable to pay the moderate co-insurance fees, these are taken care of by the province under its policy of ensuring that none of our people shall be denied essential hospital services through lack of financial resources.

*mtg. Sept 612
Persons
Came - 7 days
Police
Arrested*

10. It is our submission that this arrangement under which those unable to pay are taken care of by society collectively while those who are able to pay are required to bear a reasonable portion of the total costs with government subsidization being provided only to the extent necessary to bring the services within their financial reach is a much more preferable arrangement than so-called free health services where all direct individual financial responsibility is removed. The Government of Alberta has consistently opposed so-called socialized health and medical services, believing that such programs are incompatible with the rights and responsibilities inherent in a free and democratic society and that they have basic weaknesses:

1. When the total cost of a health or any other social service is paid directly by the state it creates the false impression that such services are free to the citizens of the province or country. The fact is, of course, that the same citizens are paying for the service whether they pay it directly in whole or in part, or by taxation. The aggregate cost is more rather than less when the state is interjected between the citizens receiving the service on the one hand and paying the bill as taxpayers on the other.
2. The socialization of health services is destructive to the traditional and desirable patient-doctor relationship and

the preservation of human dignity in this very personal field. These circumstances are important and essential if professional groups are to provide services to their patients under conditions which will ensure that the quality of their services will not suffer from unnecessary quantity demands and which provide the necessary stimulus to young men and women of our nation to whom we must look to enter such vocations. We believe that only by maintaining a system in which private enterprise and individual initiative and personal responsibility combined with whatever financial subsidization is required from society collectively, can the best interests of our people in the field of health be successfully and adequately served.

11. We trust that these concepts which recognize fundamental human needs, human rights and human responsibilities will be of help in your consideration of the important matters which are the subject of your enquiry.

DEPARTMENT OF PUBLIC HEALTH

A. PREVENTIVE SERVICES - GENERAL

I. Division of Local Health Services

DEPARTMENT OF PUBLIC HEALTH

12. The Provincial Board of Health was established by The Public Health Act in 1907. It consists of the Deputy Minister of Health, the Provincial Sanitary Engineer and the Provincial Bacteriologist.

13. It is directed that the Provincial Board of Health shall take cognizance of the interests of health and life among the people of the Province.

14. The Department of Public Health, Province of Alberta, has the responsibility of carrying out the many programs designed to prevent and treat disease.

PREVENTIVE SERVICES - GENERAL

Divisions of Local Health Services

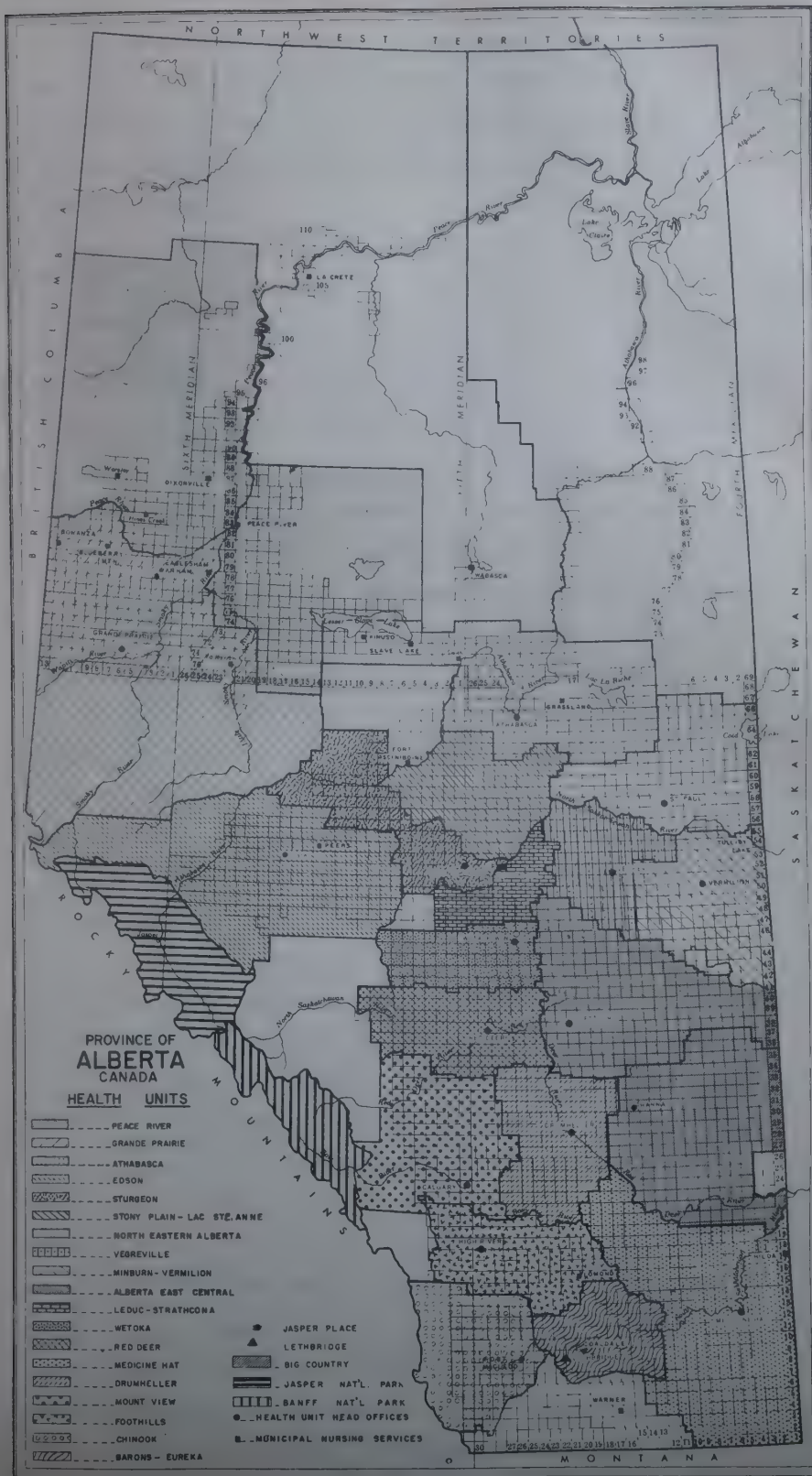
15. The Division of Local Health Services consists of the following branches:

- (1) Health Units
- (2) Communicable Diseases
- (3) Public Health Nursing
- (4) Health Education
- (5) Dental Public Health

16. The Health Units branch and the Communicable Diseases branch are the immediate responsibility of the Director of Local Health Services, while each of the other branches has a separate director of its own. Within the administrative framework of the Public Health Nursing branch, the Division has a Nursing Consultant in Maternal and Child Health, and similarly within the framework of the Health Education branch the Division has a Public Health Nutritionist.

17. The primary function of the Division of Local Health Services is to advise local Boards of Health and their staffs on matters of public health administration, and to assist them in the execution of their responsibilities. To this end the professional members of the Division are available in a consultant capacity.

18. The directors and consultants of the various branches maintain a close liaison with other divisions of the De-



partment of Public Health, with other departments of the Provincial Government, with the Department of National Health and Welfare, with the University of Alberta, with professional organizations, and with numerous other agencies which are concerned with particular aspects of public health.

HEALTH UNITS

Present Services

19. The first Health Units were established in Alberta in 1931 with the object of providing rural communities with public health services comparable to those enjoyed by the residents of larger cities. Since the introduction of The Health Unit Act in 1951 there has been a steady expansion of Health Unit services, until there are now 24 Health Units serving a combined population of more than 734,000. Although cities with a population in excess of 50,000 are specifically excluded from participation in Health Units, it is nevertheless under the authority of The Health Unit Act that the cities of Edmonton and Calgary, with a combined population of nearly 518,000, receive grants from the Department. There remains a population of approximately 44,000 (excluding Indian reservations and the Alberta portion of Lloydminster), or less than 3.4% of the eligible population of the province, that is not yet provided with public health services under the terms of this legislation.

20. Each Health Unit is administered by a Board which consists of councillors from the major participating municipalities. The Board of a Health Unit is completely autonomous, and the role of the Health Units branch of the Division of Local Health Services is merely to provide assistance and advice in relation to administrative problems, and to ensure that the provisions of the Health Unit Act are carried out.

21. The services provided by a Health Unit are free to the individual, and include the prevention and control of communicable diseases, a maternal and child health program, a school health service, a health education program and a sanitary inspection service. Dental services for the particular benefit of children may be provided at the option of local Health Unit Boards, and have in fact already

been implemented in 16 of the 24 Health Units.

22. To operate these services, a Health Unit employs a Medical Officer of Health (full-time except in three Health Units) a number of Public Health Nurses depending upon the size of population served, one or more Sanitary Inspectors, one or more Stenographers, Technicians, and a part-time Secretary-Treasurer; where dental services are provided, there is also a Dental Officer and a Dental Assistant.

23. Each Health Unit (with the exception of those in Banff and Jasper National Parks) receives a grant for general health services at the per capita rate of \$1.45 less one cent for each thousand of population served. For sparsely populated Health Units there is an additional grant for general health services at the per capita rate of 5 cents for each person or part of a person by which the population density falls short of five per square mile. A grant for dental services is available at one-fifth of the rate of grant for general health services. In order that a Health Unit may qualify for these grants, the participating municipalities must contribute at a rate not less than two-thirds of the departmental rate.

24. The Health Units at Banff and Jasper each receive a grant for general health services at the rate of \$1.25 per capita, and a grant for dental services at the rate of 25 cents per capita. Since the National Parks are provided with certain public health services by the Federal Government, they are not required to qualify for these grants by means of local contributions.

25. The cities of Edmonton and Calgary each receive a grant for general health services at the rate of 50 cents per capita, and a grant for dental services at the rate of 10 cents per capita. It is known that these grants cover less than one-third of actual operating costs.

26. The cost of local health services, in City Health Departments as well as in Health Units, is shared between federal, provincial and municipal governments. The distribution of costs during the last three fiscal years is shown in the following table:

Source of Contributions	1958 - 59	1959 - 60	1960 - 61
Federal	\$ 563,200.00	\$ 324,600.00	\$ 492,100.00
Provincial	339,300.00	641,300.00	659,400.00
Municipal	897,400.00	1,062,400.00	1,141,400.00
T o t a l	\$1,799,900.00	\$2,028,300.00	\$2,292,900.00

27. It will be seen from this table that, as the cost of these services goes up, the combined contribution from federal and provincial governments is steadily falling away from the proportion of 60 per cent which has been the traditional level of financial support for Health Units in Alberta since 1951. The burden is becoming particularly heavy for Health Units with small populations, and there is a recognized need for an increase in the rate of Health Unit grants.

Future Needs

28. It is considered that the scope of services provided by Health Units could eventually be broadened to include:

- (1) Selective mass screening for the early detection of such diseases as diabetes and glaucoma;
- (2) Increased participation in the follow-up of handicapped persons;
- (3) Participation in the follow-up of patients discharged from mental institutions; and
- (4) Administration of a rural home nursing care program, in the event that such a program were considered necessary.

Projection of Costs

29. An estimate of projected costs for local health services in Health Units and City Health Departments is shown in the following table:

Source of Contributions	1961	1971	1976	1981
Federal-Provincial	\$1,151,500.00	\$2,091,000.00	\$2,412,000.00	\$2,775,000.00
Municipal	1,141,400.00	1,394,000.00	1,608,000.00	1,850,000.00
T o t a l	\$2,292,900.00	\$3,485,000.00	\$4,020,000.00	\$4,625,000.00

COMMUNICABLE DISEASES

Present Services

30. The Communicable Diseases Section of the Division of Local Health Services is responsible for:

- (1) The collection, preparation and transmission of information, and the compilation of statistics, concerning the morbidity and mortality of communicable diseases;
- (2) The provision of consultant services to local health authorities on matters relating to the control of communicable diseases;
- (3) The direction of control measures against communicable diseases in areas administered by the provincial government which are outside the jurisdiction of Health Units;
- (4) The interpretation and distribution of Communicable Disease Regulations;
- (5) The distribution of immunizing antigens and sera, and supervision of the utilization of those in limited supply;
- (6) The appraisal of immunization programs, and the publication of specific recommendations in relation to them.

31. The statistical work of the Communicable Diseases Section is carried out in close liaison with the Dominion Bureau of Statistics, while the epidemiological phases of the work involve frequent exchanges of information with the Epidemiology Division of the Department of National Health and Welfare. The distribution of bio-

logicals is undertaken with the co-operation of the Provincial Laboratory of Public Health.

32. The work undertaken by the Communicable Diseases Section has increased very considerably over the last two years, partly as a result of the introduction of a new scheme for the distribution of biologicals (which led to a saving of over \$40,000 in its first year of operation alone), and partly as a result of the recent introduction of a more comprehensive system for the reporting of notifiable diseases.

Projection of Costs

33. The principal item of expenditure in the control of communicable diseases is the cost of biologicals. An estimate of projected costs for these is shown in the following table:

Year	Cost of Biologicals
1961	\$125,000.00
1971	146,000.00
1976	161,000.00
1981	178,000.00

PUBLIC HEALTH NURSING

Present Services

34. The Public Health Nursing branch operates within the Local Health Services Division and its major function is to assist local health authorities in the development of public health nursing programs.

35. The Public Health Nursing Director provides consultant service to the Medical Officers of Health and Senior Nurses in each of the 24 Health Units, and she assists local health authorities with recruiting, placement and orientation of Public Health Nurses, and with the organization of new nursing services.

36. The Public Health Nursing Director is also responsible for the administration and supervision of the Municipal Nursing Services, which provide a limited treatment service in

addition to a preventive program in isolated communities which are remote from medical aid. In-service training for Municipal Nurses, in the form of a refresher course, is conducted annually.

37. The Nursing Director makes regular visits to the Health Units and Municipal Nursing Services, and in some instances several visits a year may be required.

38. There is a need for an extension of public health nursing services which cannot yet be implemented due to lack of funds. There is also a continuing and increasing need for the recruitment and training of Public Health Nurses, and particularly for the training of supervisors.

Future Needs

39. The future need for public health nursing in Alberta is considered to include:

- (1) The creation of Public Health Nursing Assistants to enable Public Health Nurses to devote more of their time to the skills in which they have been specifically framed.
- (2) The utilization of Voluntary Auxiliary Assistants for unskilled tasks which are presently carried out by paid employees.
- (3) The further development of public health nursing services in isolated communities.
- (4) The possible establishment of a rural home care nursing program.

Projection of Costs

40. An estimate of projected costs for Municipal Nursing Services in isolated communities is shown in the following table:

*Shouldn't the cost
of these services
gradually reduce?*

Year	Cost of Municipal Nursing Services	
1961	\$108,500	
1971	135,000	
1976	147,000	
1981	160,000	??

MATERNAL AND CHILD HEALTH

Present Services

41. A Nursing Consultant in Maternal and Child Health was added to the Public Health Nursing staff in 1959 with the object of reducing still further the maternal and infant mortality rates which have steadily declined in Alberta since the introduction of free maternity hospital in 1944.

42. The Nursing Consultant's work is directed towards the co-ordination of public health and hospital services. Her activities include:

- (1) In the public health field, participation in staff education programs and field-work with a view to stimulating interest in the improvement and extension of preventive services.
- (2) In the hospital field, improvement of working relationships with Public Health Nurses through the promotion of joint activities such as prenatal classes and the establishment of referral programs designed to ensure continuity of patient care between the hospital and the home.

HEALTH EDUCATION

Present Services

43. The Health Education branch provides an information service for the general public in addition to a consultation service for public health personnel and other professional groups. The program consists not only in the preparation and distribution of literature and films covering a large range of health topics, but also in the presentation of talks and the conduct of discussions, institutes and workshops. There is a steady demand for the services of this branch from individuals and organizations of many kinds, including teachers, students, home and school associations, community organizations, service clubs and women's groups.

44. Included on the staff of the Health Education branch is a Public Health Nutritionist, whose services are sought after by hospitals, institutions, welfare agencies and industrial

groups as well as by the many individuals and organizations already mentioned.

DENTAL PUBLIC HEALTH

Present Services

45. A Dental Public Health branch was added to the Division of Local Health Services with the half-time appointment of a Director of Dental Public Health in August, 1959.

The functions of this branch are:

- (1) On behalf of the Department, to encourage, provide financial aid and assist with the planning, organizing and maintaining of a comprehensive dental public health program in all local Health Units and City Departments of Health throughout the province.
- (2) To advise and deal with matters pertaining to dental public health, and
- (3) To serve as a liaison for the Department to the dental and other health professions and other groups or individuals in matters related to dental health.

The activities of the Department of Public Health in the field of dental public health may be considered under the following headings:

Preventive Dental Public Health Programs

46. The Department makes available to all Health Units a dental health grant equivalent to one-fifth of the Health Units general health services block grant. This grant must be matched locally by two-thirds of its amount. Any amount spent over this basic budget must be contributed locally.

47. Sixteen of the twenty-four local Health Units operated a dental health program in 1961. Six employed the services of a Dental Officer of Health on a full-time basis, two on a half-time basis. Two units were served on a continuous part-time basis by local practicing dentists. Two units conducted a summer program

with services provided by a dentist and a third-year dental student. The remaining units employed third-year dental students to provide preventive, dental services only. The programs are basically preventive, providing dental health education, examination and referral, consultation, prophylaxis and topical fluoride applications. Some programs provide limited treatment services to the younger age groups. The financial aid from the Department in the form of dental grants to Health Units amounted to approximately \$118,000.00.

48. In addition, dental services grants are available to cities with populations over 100,000 to the amount of 10 cents per capita. Both the cities of Calgary and Edmonton operate a dental services program under the direction of a full-time Dental Director with graduate public health training. These programs emphasize prevention, but do provide more treatment services, particularly to the marginal income groups. The financial support to these cities under this arrangement amounted to approximately \$50,000.00.

Volunteer Private Practice Programs in Outlying Areas

49. One of the dental health problems in Alberta is the inequitable distribution of dental services between the urban and rural areas, at the expense of the outlying districts of the province. The Department of Public Health in conjunction and with the full support of the Alberta Dental Association initiated a program to alleviate the situation. An outlying area, in which no dental services are available, may request the visit of a dentist for a period of one to three weeks to provide his services in that area on a private practice basis. The community is responsible for providing office facilities, and is expected to arrange personal accommodation for the dentist, to publicize the time and place of the program, and to arrange for the services of a local volunteer to assist the dentist in booking advance appointments and with routine office procedures. The patient receiving the service is responsible for making his appointment, for the type of service he wishes to receive, and for payment of that service.

50. The Dental Association arranges for dentists from urban centres to visit these communities as these programs are

requested. The dentists participate in this program on a voluntary basis, sometimes at personal sacrifice to themselves.

51. The Department of Public Health provides transportable dental equipment units and a travel grant to the participating dentist. The Department and local Health Unit personnel serve as a liaison between the local districts and the Dental Association.

About fifteen of these programs have been conducted throughout the province over the last year and a half, at a total to date, including cost of equipment, of approximately \$10,000.00. This program demonstrates the advantages of understanding and co-operation between government, and the profession and the people in a concerted approach to a mutual problem.

Education

52. This Department, through its Division of Health Education, makes available and distributes dental health education material including posters, pamphlets, booklets, films and film strips to the health and teaching professions and to any interested individual or group.

Professional Training

53. The Department of Public Health makes available Federal Professional Training Grants on the recommendation of the Deputy Minister of Health. These are available to dentists in public health services and to students enrolled in the "dental auxiliary" course, Faculty of Dentistry, University of Alberta.

Dental Auxiliary Personnel

54. The Department, with the help of the dental profession and dental laboratory technicians, initiated legislation to give recognition to and provide a means for standardizing and upgrading the training of registered dental technicians.

55. The Department, with the co-operation of the Dental Association and the University of Alberta, drafted plans for the training of Dental Auxiliaries. The training of Dental Auxiliaries is a two-year course in the Faculty of Dentistry. Initially, the course is based upon the course of training for Dental Hygienists

at the University of Toronto. The Dental Auxiliary on graduation will work with the public health team in local Health Units and City Departments of Health to provide more preventive services, so essential in any dental health program. Twenty students were registered for the first course of training which began September, 1961. Fifteen of these students are from Alberta, four from Saskatchewan and one from Ontario.

Future Needs

56. Under the present system of grants to Health Units it is the Health Unit Board, with the counsel of the Medical Officer of Health, which decides on the initiation of a dental health program and to a large degree the nature of that program. However, the following comments are offered in relation to preventive dental public health programs.

57. It is desirable that all Health Units initiate a preventive dental health program at the earliest practical date. Initially, the program should be tailored to fit the available financial and manpower resources and the general level of appreciation of dental health in the area. The program should then be expanded to a comprehensive one, as availability of resources permits. The program should be basically preventive, providing dental health education and promoting the use of all proven dental public health prevention and control measures. The program should be under the direction of a Dental Officer of Health working as a member of the Health Unit team. However, the part-time Dental Officer of Health, the summer program using the services of a dentist and a third-year dental student, and the summer program using the preventive services provided by a third-year dental student are excellent stepping stones to a full-time program. In some instances, the needs of the Health Unit may warrant only part-time services.

58. The services of the Dental Auxiliary, when she becomes available, should be seriously considered by all Health Units because of the excellent preventive aspects. As a program becomes well organized by the Dental Officer of Health in one Health Unit, and as the services of the Dental Auxiliaries become more

readily available, it may be practical to suggest that two adjoining Health Units share the services of a Dental Officer of Health supplemented by the services of a Dental Auxiliary working in each Health Unit. Rather than undergo immediate geographic expansion, existing programs should be expanded in scope - and well consolidated.

59. Although treatment is sometimes a necessary part of prevention, the provision of treatment services by Health Units should be limited to the very young age groups; older children should invariably be treated by the dentist in private practice, so that the dentist in the public health field may be left free to provide the educational and preventive services which are so essential to the success of a dental public health program.

60. Dental health surveys should continue to be carried out at the earliest practical date in all Health Units.

Projection of Costs

61. In the next four to six years it is likely that all or nearly all of the twenty-four Health Units will have some form of dental program in operation. It is possible that in some cases neighbouring Health Units will share the services of a Dental Officer. It is also anticipated that by that time there will be an adequate supply of Dental Auxiliaries available for Health Unit employment.

62. On the basis of these assumptions, it is estimated that by the end of this period the annual grant to Health Units for dental services will amount to \$250,000.00.

A. PREVENTIVE SERVICES - GENERAL

II. Division of Sanitary Engineering

11. DIVISION OF SANITARY ENGINEERING

63. The functions of this Division are in the field of environmental sanitation and thus work both directly and indirectly in the 'Preventive Medicine' field. The 'quality' control of the atmosphere, surface waters, public waterworks and sewage systems, building plumbing, swimming pools, milk supplies, public eating places, industrial camps and refuse disposal is the main responsibility.

64. The total staff is now 25 and the 1960-61 expenditures were \$165,000.00, \$108,000.00 of which was for payment of staff salaries. Annual expenditures during the past ten years are indicated on the attached graph. ^{? where is it} It will be noted that a large increase has occurred in the last four years, which has been largely due to the necessity to undertake air and water pollution control work, particularly in oil and gas fields, gas processing plants and the development of the petro-chemical industry.

65. The projection of the staff and expenditures in future years is influenced not only by the expected expansion in population and industrial activity, but also by new activities generated by changing habits of the people and new methods of food processing and handling. Milk processing and handling is presently undergoing quite radical changes and this trend will, no doubt, continue. The use of radio-active materials in industry, medicine and science research is expanding rapidly. Shorter working hours, a higher level of personal income, good highways and more automobiles are all changing the recreational activities of the people. Air and water pollution control work will be influenced by this changing pattern and by the extent of urban and industrial growth in Alberta.

66. The estimated expenditures based on anticipated needs are as follows:

<u>1951</u>	<u>1961</u>	<u>1971</u>	<u>1981</u>
\$23,500.00	\$165,000.00	\$332,500.00	\$412,000.00

67. During the past fifteen years there has been a marked increase in the number of municipalities with water and/or sewage systems. The number of water works systems increased from 36

to 196 and the sewage systems from 32 to 204 during the period from 1946 to 1961. This has been made possible through municipal loans. Future work is anticipated to be largely in the maintenance and operation of existing systems, particularly those serving municipalities of less than 5,000 population. The evaluation of water treatment and corrosion in these systems assume increasing importance. The continued evaluation of the adequacy of the water supply and sewage disposal facilities will be required.

*Municipal Revol.
from fund
of M.C.
by Prov. Govt.
Exhaustion of
capital resources
→ funds that
were put to use
in creating new
capital resources
e.g. water, sewer
works, etc.*

68. Air and water pollution control has expanded very rapidly in the last ten years and it is anticipated that further extensions will be necessary to keep pace with the urban and industrial growth in the province. The processing of natural gas and oil containing hydrogen sulfide results in the venting of both hydrogen and sulfur dioxide in very appreciable quantities, and requires assessment and control. The limited flow of water in the rivers, particularly those serving central and southern Alberta, will require continued assessment and detailed review of industrial effluents released, or proposed to be released, to them. The expected population increase in the province is most likely to occur to a very large degree in the Calgary and Edmonton areas and this will accentuate both the water and air pollution control aspects in these areas. The evaluation of meteorological conditions, relating to air pollution in Alberta, is an important aspect which requires attention in the near future.

A. PREVENTIVE SERVICES - GENERAL

III. Division of Social Hygiene

III. DIVISION OF SOCIAL HYGIENE

69. This Division is responsible for treatment and control of venereal diseases in Alberta.

The Director, who is a specialist physician, co-ordinates the work of the Division with other venereal disease programs, health agencies, civic and rural health departments. He is responsible for the over-all administration of the Division and the co-ordination of diagnostic and treatment services, epidemiology, social service and education.

Diagnostic and Treatment Facilities

(a) Clinics

70. The services of the Provincial Clinics operated at Edmonton, Calgary and Lethbridge are free to all persons without restriction. A full range of diagnostic and treatment services is available. A qualified consultant is in charge of each clinic to see all patients attending and to direct treatment and follow-up care. Clinics are also operated in the three provincial gaols, Fort Saskatchewan, Spy Hill and Lethbridge, and there is a mobile clinic which can be sent to any area of the province where a need is indicated.

(b) Consultative Service

71. Consultative service is provided by the staff of the Division of Social Hygiene to private practitioners and municipal nurses; it may be requested by letter, telephone, or personal contact with clinical personnel in each centre. All problems are brought to the attention of the Director in Edmonton.

(c) Drugs

72. Free medication is given to patients attending the clinics and is also supplied upon request to any qualified physician for the treatment of any person reported by him as suffering from venereal disease.

(d) Laboratory Services

73. Free laboratory tests for the diagnosis and follow-up of venereal disease patients are provided by the Provincial Laboratory situated at the University of Alberta in Edmonton and its southern branch in Calgary.

Epidemiological Facilities

74. The epidemiological section of the Division comprises a team of public health nurses and male workers which is responsible for the development and maintenance of an adequate case finding and case holding program within the province.

75. Many persons with venereal disease are emotionally disturbed; some have marital and family troubles; others are in financial difficulties, and still others are victims of a below average intelligence and ability. These are all basic problems which must be looked after if the patient is to gain any real insight into the relationship between his infection and his promiscuous behaviour. In the instance where a patient is hampered by his or her response to medical care, available opportunities are utilized for discussion of the problem and, if necessary, the individual is referred for help to one of the social service agencies in the community.

Statistical Reports

76. The Division is responsible for keeping records and preparing statistical reports on venereal disease incidence. However, details of these matters are confidential between doctors, patients and the Division.

A. PREVENTIVE SERVICES - GENERAL

IV. The Provincial Laboratories

IV. THE PROVINCIAL LABORATORIES

77. The Province of Alberta maintains a Laboratory in both Calgary and Edmonton. These laboratories provide examinations in the fields of pathology, bacteriology, virology and related fields, which are essential to the physician in the treatment of illness, and also in the prevention and spread of disease.

78. During 1960 the pathology section examined and reported on some 32,000 blocks of tissue removed during surgery. Cancer was detected in some 7% of the cases examined. The reports of the laboratories play a large part in determining the surgical procedures carried out on many patients and frequently provide vital diagnostic information in cases other than cancer. Because of the increasing clinical demand for the cytological examination of cervical secretions, a screening service for cancer cells has been set up in the Edmonton laboratory and it is planned to extend this to the Calgary laboratory when adequately trained staff has become available.

79. The laboratories play an active part in diagnostic and preventive bacteriological determinations, mycological examinations, venereal disease control and tuberculosis control.

80. The Provincial Laboratory in Edmonton provides a virus diagnostic service which has been in the process of development since 1959. Diagnostic procedures can now be applied in detection of influenza A and B, Psittacosis, Q Fever, Adenovirus infections, Mumps, Rocky Mountain Spotted Fever, Poliomyelitis and Coxsackie infections to mention a few.

Possible Future

Development of Laboratory Services in Alberta

81. Thus in any organized health scheme laboratory facilities must be provided to serve the needs both of the individual and of the community. These needs are somewhat different. The individual, as a sick person, may require laboratory help in order to get well, the community requires laboratory help in order to keep well. Responsibility for the individual lies primarily with his physician, responsibility for the community with

the health authorities.

- (a) Laboratory services for the individual must be
 - 1. Of uniform availability
 - 2. Of uniform standard
 - 3. Of the highest quality compatible with
national or provincial economy
- (b) To be uniformly available the service must be organized on a regional basis, preferably in association with regional hospitals.
- (c) To be of uniform standard the regional hospital laboratories must have some central guidance or control and they should have access to an adequate central consultant and reference service. Their staff members should take part regularly in centrally organized discussion groups, workshops, slide seminars, quality-control programs, etc., and each regional laboratory should operate under a provincial licensing system relating to staff and facilities.
- (d) To achieve quality with maximum economy there must be considerable centralization of the more difficult, unusual or expensive tests.
- (e) Laboratory services to the community must have
 - 1. Uniform application
 - 2. Wide scope
 - 3. Adequate ancillary information
- (f) To have uniform application the service should be centrally organized and should be based mainly on special central laboratories.
- (g) To have wide scope the service must be closely integrated with provincial, national and international services of similar nature.
- (h) To have adequate ancillary information the laboratory service to the community must be closely associated with provincial authorities and especially those de-

partments concerned with water, food, environment, and epidemiology in its widest sense.

Application To Alberta

82. The laboratory service within the province can be developed from its present structure by natural growth stimulated by provincial/federal help and controlled by new provincial legislation.

- (a) Laboratory Service for the Individual:- This service will be based on present and future regional hospitals and will require both in-patient and out-patient laboratory facilities. In each area the size and scope of individual new laboratories can be fairly easily controlled by the allocation of building and equipment funds on some predetermined plan. Legislation will be necessary to ensure that the service, no matter whether it is organized as part of a national health scheme, on a communal insurance basis, or by private enterprise, is related primarily to the regional area and the needs of its inhabitants. This should prevent the over-multiplication of laboratories in centres of high population density, ensure the uniform availability of all urgently necessary tests in every area and provide some guarantee of their quality. To this end some professional salaries in remote areas will have to be provided or subsidized even if fee-for-service happens to be the currently acceptable basis of remuneration, and the operational costs of the laboratories will have to be assessed on their quality and capacity in addition to the work-units they produce.
- (b) Uniformity of standards requires central organization but peripheral acceptance. No standard of laboratory work can be legislated into existence, but a uniformly high level should be demonstrated in the consultant and reference service, encouraged by the centralized

provision of standards and special test materials, and controlled by mutual inter-laboratory evaluation and training programs. In the provision of such central consultant and reference facilities the present Provincial Laboratories should play an important role especially if their status can be confirmed or raised by University or teaching-hospital association.

- (c) Economy of regional services can best be achieved by remembering that not all laboratory tests are urgent and not all tests can be carried out in every laboratory. Some examinations require special skills or special experience and even some simple tests such as serological tests for syphilis must be done in large numbers to ensure sufficient control sera. Thus facilities for such tests need be provided only in a few laboratories. Virus isolation and identification, species identification of salmonellae, phage typing of staphylococci, fungus identification, are among such tests and are already carried out in the Provincial Laboratories which should retain these interests. Other tests such as cytological screening for cancer cells may or may not be centralized in the future depending on costs and local interest but obviously will have to be considered. And, of course, the valuable centralized facilities of the Red Cross Blood Transfusion Service should be gratefully acknowledged in any provincial planning.

Laboratory Service to the Community

83. The control of community health must be centrally organized. Therefore, the necessary laboratory services should come directly under the central health authorities. The present Provincial Laboratories are currently in close touch with provincial health authorities and, if the southern laboratory is moved into Calgary, will both be situated in the main centres of population.

(a) Uniform application to the community of the results of laboratory tests can best be achieved by the appropriate health authorities who will often be acting under provincial regulations. The Provincial Laboratories are currently providing such results to these authorities in relation to water supplies and communicable diseases. There are strong arguments in favour of maintaining this practise. In occasional instances regional hospital laboratories, and more frequently regional public health authorities, will play some part in water control, and undoubtedly regional hospital laboratories will often be involved in the preliminary diagnosis of communicable disease. Yet if the Provincial Laboratories become adequate reference centres for local authorities and for regional laboratories they will be regularly consulted on water control and will regularly receive reference specimens and reports which will indicate the epidemiological distribution of disease in the province. This will be particularly true in virus infections, in enteric and food poisoning infections and in epidemics of other bacterial diseases. Again, the main centres of population will also be the main centres of distribution and thus the Provincial Laboratories are ideally situated to carry out the greatly extended examinations which will undoubtedly be required in the future in connection with food-stuffs.

(b) Wide scope of community laboratory services can also be secured best through the Provincial Laboratories. Their Director is ex-officio a member of the Technical Advisory Committee on Public Health Laboratory Services to the Federal Minister of Health and Welfare and thus is in direct contact with the public health laboratories of other provinces and

with national and international laboratory services. The integration of public health laboratory services across Canada is a major concern of the above committee.

- (c) Adequate ancillary information on health and other community problems is obviously already available to the Provincial Laboratories in their position as part of the structure of Provincial Government.

Summary

84. Laboratory services suitable to the needs of the sick person can best be supplied through a system of regional laboratories associated with regional hospitals. With both in-patient and out-patient facilities these laboratories will provide all the immediately necessary examinations to their own areas. They will refer some less urgent material and all highly specialized examinations to central reference laboratories which in turn will endeavour to correlate the activities of the various regional laboratories and encourage them by all available means to maintain high standards of work.

85. Laboratory services suitable to the needs of the community can best be supplied through a system of central laboratories specializing in matters such as standards of water, food and environment and in the control of communicable disease. A close connection with central health authorities is essential for the effective application of the activities of such laboratories.

86. In many areas presently available hospital laboratories can be developed into main or subsidiary regional laboratories. Others will have to be built along with new regional hospitals. Laboratories with special facilities in the larger centres can become reference laboratories, but the Provincial Laboratory organization and other laboratories associated with University centres might well become the hub of this reference laboratory system. The Provincial Laboratories will also be the obvious selection as central laboratories specializing in matters of community health.

87. Standards of laboratory performance can best be maintained by mutual help and agreed inter-laboratory evaluation procedures. Performance cannot be imposed by regulation but some pro-

vincial legislation will be necessary to determine, perhaps by licensing, that the facilities and staff of individual laboratories are equated with their area responsibilities, and to ensure, perhaps by appropriate allocation of funds, that laboratory services are adequately distributed through the province.

88. Since the above is a comprehensive suggestion of future development for laboratory facilities, all of the implications contained therein should merit careful and close study.

4 A. PREVENTIVE SERVICES - GENERAL

V. National Health Grants

V. NATIONAL HEALTH GRANTS

89. In 1948 the federal government made available a series of health grants to the provinces. The grants are designed to assist in the development and extension of public health services and are allotted to special areas such as professional training, mental health, tuberculosis control, general public health, etc.

90. Certain federal health grants such as hospitalization and cancer control, require a matching expenditure to be made by the province. The introduction of matching grants has brought pressure on the province to expand facilities in order to take advantage of the grant. In some areas at the termination of the grant it becomes difficult to control increasing cost to the province.

91. The following table shows the amount of these grants for 1960/61, the amount that was committed under the various projects, the amount that was actually expended, and the percentage of the various grants that was expended:

HEALTH GRANTS1960/61

Type of Grant	Amount Committed	Amount Expended	Percentage Expended
Professional Training	\$ 126,936.00	\$ 106,507.26	83.9%
Hospital Construction	1,361,175.00	322,083.33	23.7% *
Mental Health	631,253.00	631,253.00	100.0%
Tuberculosis Control	210,975.00	210,975.00	100.0%
Public Health Research		81,929.62	
General Public Health	1,010,580.00	986,049.10	97.6%
Cancer Control	252,063.00	252,063.00	100.0%
Medical Rehabilitation & Crippled Children	189,706.00	85,743.51	45.2%
Child & Maternal Health	123,413.00	71,722.04	58.1%
T o t a l	\$3,906,101.00	\$2,666,396.24	68.3%

* Unexpended portion of 1960/61 hospital construction has been carried to 1961/62 fiscal year and has been expended in full.

1 B. TREATMENT SERVICES - GENERAL

VI. Division of Medical Services

B. TREATMENT SERVICES - GENERAL

VI. Division of Medical ServicesDiabetic Drug Program

92. The Department of Public Health has provided to residents of Alberta, without charge, a hypoglycemic medication in the form of insulin to diabetic patients. The program has been operative for about thirty years and is provided under a 'means test'. The diabetic patient makes his application through his own physician. On April 1st, 1959, the above program was expanded to include the provision of an oral hypoglycemic medication in the form of tolbutamide for eligible cases who are capable of being treated with this agent instead of insulin. On November 23rd, 1961, 345 persons were receiving insulin and 272 were receiving tolbutamide. This service provides a saving of \$54.00 a year to the diabetic of average severity who requires insulin and \$156.00 a year for those taking tolbutamide.

Phenylketonuria Therapy Program

93. On April 1st, 1960, the Province of Alberta through its Department of Public Health brought the treatment of phenylketonuria under a special drug program. The food supplement required for treatment of infants suffering from phenylketonuria is provided without charge. Phenylketonuria is a congenital defect found in a very small percentage of newborn infants and which, when present, prevents the proper metabolizing of certain foods. The result, if not treated very early with proper dietary preparation, is mental deficiency. The special dietary preparation which is the main constituent of the diet is required for the prevention of mental deficiency. Where the diagnosis is confirmed early and mental deficiency has not developed to any great extent the Department provides this dietary supplement at a cost of \$450.00 per year per child. During 1961 there were four children receiving this dietary supplement.

Rheumatic Fever Prophylaxis Program

94. This program was implemented in June, 1958,

by the Department of Public Health and has now been in operation for three and one-half years. Any child under 18 years of age and a resident of the province is eligible for continuous prophylactic treatment under the program providing the child's physician can demonstrate a history of rheumatic fever. At the present time some 1,200 children under the age of 18 are receiving the benefits of prophylactic penicillin at a cost of approximately \$12.00 per child per year. Purchase price of penicillin on the retail market would be in the vicinity of \$80.00 per year.

Treatment Services for Social Service Recipients

Instituted in what year? 1947

95. The Treatment Services Act provides for treatment services for all the Social Services group covered by the Department of Public Welfare Social Allowance and Social Assistance categories. This includes individuals in receipt of Old Age Security receiving the Alberta Supplementary Allowance; Old Age Assistance, Blind Pension; Mother's Allowance, Widow's Allowance and Disability Pension, and the dependents of these categories. The treatment services provided are medical, dental, optical, chiropractic, and certain limited services such as physiotherapy and podiatry.

Medical Care for Social Service Recipients

*1947 = 10.12/capita
Started year? how much?*

96. The Department of Public Health has an agreement with the College of Physicians & Surgeons whereby the College, through its practising members, provides complete medical care for the Social Service recipient group. The payments made for this service are \$24.00 per capita per year for each eligible individual on a basis of \$2.00 per capita per month. These monies are placed in a Pensioner's Medical Fund and the practitioners submit their accounts for the care of this group to the fund. The individual doctor is paid on the basis of fee for service after the account has first been appraised according to the College's minimum schedule of fees. The initial payment for each doctor is 50% of the value of the assessed account. Subsequently, after the administrative costs have been deducted for the operation of the fund, the remainder at

*Agreement 1959?
1960?*

the end of the year is pro-rated among the practitioners according to the assessed value of the services rendered. During the fiscal year April 1st, 1960 to March 31st, 1961, administration costs were 3.1% of the assessed value and each practitioner received as a total payment 62% of the assessed value of the accounts. The medical practitioners of the province thereby make personally a considerable contribution to the medical care of Social Service Recipients.

97. Necessary hospitalization is provided by the Hospitals Division under the Hospitalization Benefits Plan.

98. A new Child Ward group was added to the Social Services group in November, 1961. ** How many? - 2500 - 3000*

99. In 1961 there was an increase in total Social Services Recipients of 3,766 (exclusive of the Child Ward group) over the 1960 figure of 48,222. The over-all increase was 7.89% as compared to an increase of 4.75% in 1960. This indicates a continuous percentage increase of Social Service Recipients in the provincial population. The total number of Social Service Recipients was 51,988 as of November, 1961 and with the added increment of 3,500 from the Child Ward group the projected figure for 1962 would approximate 59,000.

DENTAL SERVICES FOR SOCIAL SERVICE RECIPIENTS

100. The Department of Public Health has an agreement with the Alberta Dental Association, on a basis of 40¢ per capita per month, which provides payment to the individual dentist for services given to the Social Service Recipient group on submission of his accounts to the Alberta Dental Association. This program provides routine dental care to all recipients except dentures and partial plates which are provided at half cost to eligible individuals, and posterior bridge work is not provided.

101. In 1960 the cost of these dental services amounted to \$228,568.00.

OPTICAL SERVICES FOR SOCIAL SERVICE RECIPIENTS

102. The total claim for the provision of 8,523 pairs of glasses in 1960 amounted to \$116,354.00, of which \$82,680.00 represented the cost of optical and optometric services.

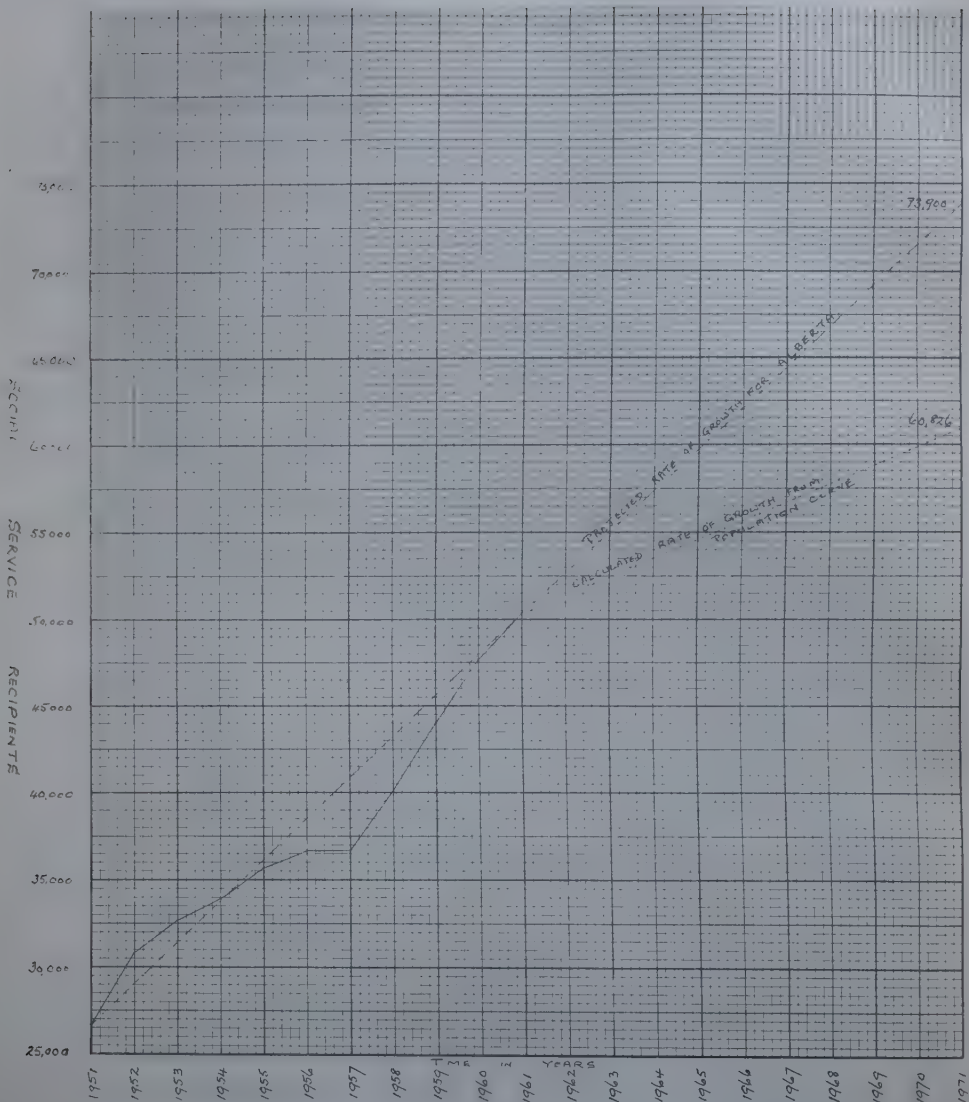
103. Provincial expenditures for treatment services on behalf of the Social Service Recipients in the calendar years 1959 and 1960 were \$1,318,031.00 and \$1,490,462.50 respectively.

104. The projected rate of growth of Social Service Recipients is calculated on the standard population curve as follows:

1961	51,988
1971	60,826
1976	67,064
1981	73,830

105. As a matter of interest, the average figures for Social Service Recipients have been taken from departmental records for the years 1951 to 1961 and plotted on the accompanying graph. A projection of this growth trend shows a Social Service Recipient population in 1971 of 73,900 as compared to 60,826 by the standard population curve. This larger population may not be valid but is of interest with respect to future cost estimates.

106. The Department of Public Health is also vitally concerned in the provision of personnel to maintain the operation of the expanding hospital scheme and various programs have been instituted in order to meet these requirements.



THE SCHOOLS FOR NURSING AIDES

107. The Nursing Aides Act, introduced in 1947, had for its primary purpose the training of women in nursing who did not possess the academic qualifications to enter professional nursing, and to give them a vocation which they could practise with personal satisfaction and contribute to the nursing field in the care of the sick. This program has fulfilled all these primary purposes admirably and at the present time it is felt that the institutional care of the sick could not function without them. They form an essential part of the nursing team.

108. With the increase in size and number of acute hospitals, and the advent of auxiliary hospitals and contract nursing homes under The Alberta Hospitals Act, 1961, and with the expanding of hospital procedures, treatments, medications, diagnostic tests and preventive measures requiring the time of the professional nurse to perform the highly technical professional duties, ever increasing numbers of nursing aides are needed to fill the gap at the patient's bedside.

109. As a result of the foregoing, the first Nursing Aide School was built in Calgary in 1947, and in 1958 at Edmonton a second school was opened. The present maximum school capacity is 600 members per year with 483 graduates in 1961, and to date a total of 3,354 nursing aides have been graduated.

*Length of course - 16 months
of nursing
in school*

THE NURSING RECRUITMENT PROGRAM

110. The active recruitment for nurses and nursing aides has proceeded continuously since 1956 and the need for ever increasing numbers continues. There has been some increase in the size of some of the Schools of Nursing in the larger hospitals, but unfortunately the number of schools for this purpose has not increased, being 11 at the present time. These schools have been operating at full capacity.

Total capacity of training schools -

111. Data taken from projection of Hospitals Division (VI) shows a hospital bed capacity of 9,629 in 1961 for Alberta and an estimated hospital personnel complement of 7,639 nursing staff to provide nursing care. The projected estimate of hospital bed

capacity in 1971 is 12,248 beds, representing an increase of 3,501 beds in a ten-year period with the major expansion in the auxiliary hospital area.

112. The nursing staff requirements are projected at 10,196 by 1971, or an increase of 2,827 in ten years, or 282 persons on an average per year. The number of student nurses enrolled in 1961 in Alberta hospitals was 1,821, and 530 were shown as graduating that year.

113. The level of nursing graduates numbering about 1,013 per year would appear to be more than sufficient. However, the present comments are only relevant with respect to hospital personnel and no mention has been made of nurses working in other areas outside of hospitals. The loss through marriage and also those leaving Canada is high and is difficult to estimate. Further, the opening of large new hospitals such as the Foothills Hospital can disturb the equilibrium.

114. Changing staff patterns are becoming evident as is shown by the following table and may result in what we consider a favourable situation at present, not being adequate in future years.

DATA FROM ASSOCIATED HOSPITALS OF ALBERTA

<u>Nursing Staff</u>	<u>1959</u>	<u>1960</u>
Directors & Supervisors in Nursing	372	333
Graduate Nurses	2,692	2,315
Student Nurses	1,456	1,635
Orderlies	274	280
Other Nursing Staff (Certified Nursing Aides, trainees)	<u>1,447</u>	<u>2,058</u>
Total Nursing Staff	<u>6,281</u>	<u>6,621</u>

115. It is to be noted that the number of graduate nurses has decreased with a considerably larger number of certified nursing aides being employed.

116. A survey of nursing care in smaller hospitals by an Alberta Nursing Care Committee Survey in 1959 has shown that one of the major needs of Alberta hospitals is in relation to the

provision of more adequately trained nursing administration staff.

117. As a result of the hospital growth there will continue to be a great demand for nurses and nursing aides and thus it is essential that continued effort must be exerted to recruit candidates for the nursing and nursing aide programs.

118. The Nursing Recruitment Officer continues to carry forward the recruitment program by means of pamphlets, posters, newspaper advertisements, radio and television. Films and film strips are used regularly. Material is prepared and distributed for use by the counsellors in the secondary schools; speakers are arranged for Career Day talks in schools. The Recruitment Officer and other local nursing personnel visit schools throughout the province advising potential candidates on career possibilities in the field of nursing.

119. It is felt that this program is proving successful in that the number of candidates available for nursing and also for nursing aide programs has now increased considerably.

THE LABORATORY AND X-RAY SCHOOL

120. This combined laboratory and radiological educational program has been operated by the Department of Public Health since 1954. Its purpose was to provide adequately trained technical personnel for the laboratory and x-ray service that was essential for the small hospitals in the province.

121. The course is of six months' duration, providing three months' training in each of technical radiology and clinical laboratory. In addition, many small hospitals have been desirous of having certain biochemical tests available in the laboratory as well as the clinical tests, and efforts are being made to provide a further two-month course for the training of technicians in the determination of blood urea nitrogen, bilirubin, blood sugar tests and prothrombin time. This extra training it was thought, would provide valuable assistance to the doctor in the management of certain cases in his local area.

122. The present program for the Division of Medical Services entails a budget of \$2,679,870.00. If projected on the

*Provides grants in aid to Cent. Nursing Aides
• X-ray Lab. Fee.
Med-Dental Services to Personnel*

population growth curve this would show the following increments:

1971	\$3,115,448.00
1976	3,407,032.00
1981	3,805,415.00

B. TREATMENT SERVICES - GENERAL

VII. Hospitals Division

VII. Hospitals Division

Joint Federal Provincial Hospitalization Plan in Alberta
Development

123. The Alberta Hospitalization Benefits Plan was introduced in the Province of Alberta on April 1st, 1958, three months prior to entering into an agreement with the Federal Government covering the joint Federal Provincial Hospitalization Plan which at present is in operation. Prior to this date a Provincial Municipal Hospitalization Plan existed, the dominant characteristic of which was the acceptance by the municipalities of a residual responsibility for operating costs plus a restricted coverage arising from the voluntary nature of the plan and the specific interpretation of residents who were eligible under the plan. The purpose of starting the purely provincial plan prior to the 1st July, 1958, was to gain certain experience in respect to problems which might be met prior to entering into the agreement with the Federal Government under the joint Federal Provincial Hospitalization Plan.

124. The administration of the Alberta Hospitalization Benefits Plan is the responsibility of the Hospitals Division of the Department of Public Health.

Under the joint Federal Provincial Hospitalization Plan the dominant characteristics were that -

- (1) all persons who qualified as residents of Alberta were covered;
- (2) the direct responsibility of the individual was limited to a deterrent or coinsurance charge ranging from \$1.50 to \$2.00 per patient day. All in-patient services including drugs were included.

125. On April 1st, 1959, long term hospital care, normally referred to as chronic care, was included on the same basis as under the standard ward care coverage being given in active treatment hospitals. Due to the shortage of beds in the chronic care area, the Provincial Government entered into contracts with nursing homes for the accommodation of the long term hospital care, involved in regard to chronic patients. As auxiliary (chronic

care) beds are constructed the temporary contracts entered into with the nursing homes are being discontinued. *Chr. Hosp. beds -* *Nursing Home beds -*

1959 1960 1961

126. Out-patient hospital services were provided to the provincial Old Age Pensioners in April, 1959, although this item was not considered as insured out-patient services under the joint Federal Provincial Hospitalization Plan since it did not conform to the necessary uniform terms and conditions in respect to all residents.

127. The limitation of the joint Federal Provincial Hospitalization Plan at the outset to standard ward service in active treatment hospitals left a patient financial responsibility gap in the areas of auxiliary (chronic) hospitalization. Although the long term hospital stay has been partially eliminated through the introduction of the auxiliary hospital program, there still remains the out-patient area in which the individual pays for the services rendered. Therefore, the situation still exists where a patient admitted in the active treatment area may receive hospital service at a lower cost than if he were admitted as an out-patient. At the present time a provincial study is being made preparatory to the possible introduction of out-patient benefits as insured services.

128. The problem of the assessment of patients as to whether or not they require hospital care as against custodial or domiciliary care has presented a problem. The significance of this particular problem has been exaggerated due both to the financial cost involved in providing custodial and domiciliary care which must be met by the patient, as well as to the limited amount of accommodation which is available in this respect. A certain degree of relief has been offered by the Provincial Department of Public Welfare which will take care of those cases in these areas which are able to conform to the necessary means assessment.

Special Aspects of the Federal Provincial Hospitalization Plan in Alberta

129. Basically the hospital services offered in the respective hospitals throughout Alberta do not differ radically from the hospital services offered in other provinces. The basic differences are primarily in financing, the payment for the services and

the organization of the hospital services presented within Alberta,
130.

Under the Provincial Hospitalization Plan the individual is entitled to hospitalization on the payment of a co-insurance charge and all persons who qualify as residents are entitled to hospital care on this basis. At the outset of the plan the co-insurance charge represented substantially the out-of-pocket costs which were incurred by the hospitals in having the individual in hospital. Although no adjustment has been made in the amount of these charges since the plan was introduced, it does appear that the amounts charged are deficient in meeting this criteria. The basis of the co-insurance charge to the individual was on the assumption that the individual was paying his own way and that the Provincial and Federal responsibility was represented by providing the facilities which enabled hospital care to be given.

131. The second characteristic of the Alberta plan is that all residents are covered and are entitled to hospital benefits. This means that any person coming into the Province is immediately covered providing he intends to make his home and is ordinarily present in Alberta. Certain modifications were made with regard to persons coming to Alberta from other provinces in which case reciprocal arrangements were worked out in order that duplicate coverage would not exist.

132. An attempt has been made to organize the hospitals of Alberta in a manner such that there will be available hospital care in the local area which will provide for approximately 80% - 85% of the needs of the community in respect to hospital care. Hospitals have been established at strategic points referred to as regional hospitals which are designed not only to serve their own area for the ordinary needs but also to provide for the partially specialized types of treatment required by the surrounding areas. It is estimated that approximately 10% of the cases which cannot be handled by the local hospital will be referred in to the regional referral centre.

133. Two major centres have been established in Calgary and Edmonton where hospital treatment of a specialized nature

is available. It is anticipated that approximately 5% - 10% of the cases arising in the local areas will be sent to these special referral centres for treatment. The types of treatment given in these areas at the present time include heart surgery and special treatment for cancer, poliomyelitis and other obscure illnesses.

134. Although the above organization of hospitals is by no means unique to Alberta it has been mentioned merely as a plan which to date has been put into partial operation by limiting to this pattern the type of new facilities provided.

135. A resident of Alberta is covered for hospital expense less co-insurance while he is temporarily absent from the province and receives hospitalization while outside the province. Special concessions are granted to students where the absence from the province is for an extended period of time if the individual is absent for educational purposes.

Technique of Control

136. In the basic planning underlying the establishment of the Federal Provincial Hospitalization Plan in Alberta an attempt was made to build into the administrative procedures as strong a degree of control of the respective areas as possible.

137. An attempt was made to eliminate detailed procedures as far as possible but at the same time to maintain an efficient control over the various aspects of the plan. This meant that information collected must meet the criteria of effective utilization. The approval of budgets at the opening of the period was not undertaken but rather, the results of operations of the hospitals prior to entering into the agreement were accepted as the basis of payment on account for the subsequent period. This basic payment was reviewed yearly on the basis of audited costs and an adjusted basic payment was determined at the end of the year. This adjusted payment represented the basis of the monthly payments made to the hospitals during the subsequent year. For a variety of reasons, each hospital has its own ceiling which changes yearly. There was imposed an over-all maximum amount per rated bed day which applied to the hospitals where costs were in excess of such maximum.

138. Due to the pressures arising as a result of bed occupancy and the basic philosophy of Government responsibility to provide hospital facilities, the financial payment procedures were developed on the basis of rated bed days rather than patient days. This step meets the many problems which arise out of varying degrees of occupancy due to conditions over which the hospital has no control.

139. Wherever possible throughout the Plan broad basic ceilings have been applied for purposes of control. This is particularly evident in the area of new construction.

140. Although controls were imposed governmentally, it entailed the maintenance of local autonomy as far as possible. In order to accomplish this end the ceiling which is applied covers a relatively broad area within which the local hospital board maintains its autonomy provided that the area under consideration, as far as costs were concerned, remained within the ceiling level established.

Administration Costs

141. In setting up the joint Federal Provincial Hospitalization Plan in Alberta an attempt was made to eliminate all unnecessary detail involved in administration but at the same time to retain those aspects which were considered to be essential for the effective economical administration of the Plan. The steps which were taken have resulted in reasonably satisfactory relationships both with the hospitals operating under the Plan as well as with federal authorities.

142. At the same time, control although of a general nature has been established supporting the trustee responsibility of the Division involving disbursements of public funds. The cost of administration has been maintained at what is considered to be a very reasonable level with the administration costs amounting to between .3% and .4% of the operating costs of hospitalization without consideration of the actual capital outlays involved in respect to construction which is also administered by the Hospitals Division.

143. The following table sets out the comparative relationships in this particular area for the year 1959 and 1960 which we consider speak for themselves.

Province of Alberta
Hospitals Division
Cost of Administration

	<u>1959</u>	<u>1960</u>
Total cost of administration of Hospitals Division	<u>\$ 136,413.00</u>	<u>\$ 168,542.00</u>
Total cost of hospitalization exclusive of administration	<u>\$39,587,000.00</u>	<u>\$46,538,000.00</u>
Ratio of administration costs to costs of hospitalization	<u>0.34%</u>	<u>0.37%</u>
Residents covered under the hospitalization plan	<u>1,232,000</u>	<u>1,272,000</u>
<u>Cost of administration per resident</u>	<u>\$0.11</u>	<u>\$0.13</u>

The Utilization of the Federal Contribution

144. Under the joint Federal Provincial Hospitalization Plan the contributions made by the Federal Government were to be applied presumably by the Provincial Government in relieving primarily the residents from a portion of the impost theretofore borne in the provision of hospital services. On the basis of this assumption the Province has attempted to utilize the federal contribution in such a way as to partially relieve the resident and the municipality in this regard.

145. The following table presents a comparison of the relative contributions by the participants in the hospitalization plan in Alberta both before and after the introduction of federal participation.

Province of Alberta
Cost of Hospitalization
and
Impost Borne by Participants

Amendment
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	<u>1957</u>		<u>1959</u>		<u>1960</u>	
Participant	Amount (\$000)	%	Amount (\$000)	%	Amount (\$000)	%
Resident	\$ 6,386	23.63	\$ 3,171	8.01	\$ 3,664	7.86
Municipality	6,577	24.33	5,963	15.06	5,983	12.86
Province of Alberta	14,039	52.04	15,107	38.17	19,143	41.14
Federal			15,346	38.76	17,748	38.14
T o t a l	\$27,002	100.00	\$39,587	100.00	\$46,538	100.00



146. The above table illustrates the policy adopted by the Province of stabilizing the contribution made by the resident and by the municipality to the hospitalization plan and the assumption by the Province jointly with the Federal Government of the residual position in respect to the increasing costs entailed by the Plan. These additional costs are represented by the normal increase in cost as a result of the changing price level plus the provision of improved service and the normal increase resulting from an increase in population. It is rather interesting to note that the contribution in dollars made by the Province in the year 1960 is in excess of the contribution made in the year 1957 prior to the date when the federal contributions began.

147. A review of the utilization of the federal contribution across Canada shows a varied pattern. We consider this to be significant from the standpoint of the purpose of the introduction of federal participation in any plan whether it be hospitalization or medical care.

Federal Provincial Relationships

148. Although the general day-to-day relationships between the Federal Government and the Province of Alberta in the Federal Provincial Hospitalization Plan have been quite satisfactory, serious differences of opinion have arisen in respect to certain areas. It has been found relatively difficult to obtain satisfactory arrangements covering those areas where differences of opinion have arisen. Insofar as the Federal Government is making a payment to the Province in respect to hospitalization carried on for the residents of the Province, an attitude appears to have developed that the Federal Government assumes the role of senior partner in the joint Federal Provincial Hospitalization Agreement and even in some instances assumes a partly dictatorial role. As partners in an agreement the Province is of the opinion that they should be treated as such rather than be arbitrarily asked to accept decisions which might be made at the federal level. In any joint venture of this nature it is strongly recommended that provision be made whereby such items might be dealt with by an independent board. *if Fed. govt not made to provinces to use as they see fit for hospitalization.*

149. From the date of the introduction of the Plan the attitudes of the Federal Government with regard to co-insurance paid by the residents on hospitalization has been questioned on the grounds that it is discriminatory. Our position is that if the purpose of the plan was to share in the operating costs, there does not appear to be any justification why the resident patient's contribution towards these costs made at the time of hospitalization should be differentiated from the resident's contribution in the way of a premium. Although it is difficult to specifically prove that the co-insurance requirement is a deterrent in the Alberta Hospitalization Benefits Plan it is our opinion that to a degree it does serve this purpose.

150. We are presenting copies of the 1960 Annual Report of the Hospitals Division for inclusion as part of our submission.

See that copies are given to Commission

Projections of Hospitalization Experience to 1971, 1976 and 1981

151. The schedule is a projection of the picture of present activities having regard to certain assumptions which it is usually necessary to make in studies of this kind. The hospitalization field is a constantly changing and adjusting thing which adapts itself to the demands of the public through their government, to innovations in methods and efficiency in rendering treatment, and to the ever-changing needs for the provision, either of more or less facilities for different aspects of treatment and care as determined by such aspects as prevalence of disease and age composition of the population.

152. Following are the assumptions that have been made in the compilation of these projections. It is realized that there are many other assumptions that could have been made and for this reason it is considered imperative to enumerate only those that have been made.

153. Population - Projected population figures, as provided by the Alberta Bureau of Statistics, have been used as a base in relation to which present experience has been expanded. The projected population figures would indicate a population increase of 16.6% by 1971, 28.8% by 1976 and 42.2% by 1981.

154. Hospital Beds - The present rate of general hospital beds per 1,000 population is approximately 6 and this has been used in the schedule throughout to 1981. It is the present intention of the Hospitals Division to increase auxiliary (chronic) hospital beds from the present 3/4 to a rate of 2 beds per 1,000 population and this figure, also, has been used through to 1981. It is recognized, however, that in the foreseeable future, factors such as improved methods of treatment, the eventual institution of comprehensive out-patient programs, the introduction of Progressive Patient Care concepts, may result in lower per capita bed requirements than those indicated, with corresponding economics in the provision of such services.

155. Hospital Personnel - The present ratios of numbers of personnel per hospital bed have been projected in an attempt to show the future situation in the light of present actual conditions. Once again, however, it will be appreciated that constant improvement in staff utilization will very probably result in a shift of hospital personnel patterns. It is expected that the ratio of personnel per chronic hospital bed may decrease somewhat as our experience grows in the provision of this type of service. The utilization of Progressive Patient Care concepts will inevitably lead to economies in that less specialized staff is required as the intensity of treatment needed for specific types of patients decreases as they progress along their road to recovery.

156. There will in all likelihood be a change in the ratios of the different types of personnel required. Constant studies are being undertaken by various professional associations to enable themselves to meet the demands of changing conditions. Whenever special problems arise in connection with any specific types of personnel, the Alberta Department of Health has played an active role as to their study and solution. Currently, a Nursing Education Survey Committee of five is studying all aspects of nursing education and the associated problems of recruitment of the different types of nursing personnel required in satisfactory operation of the Alberta Hospitalization Benefits Plan.

*By Earl Sawloff
Reg. Adm. Head
Mrs. Johnson
Mrs. Campbell
Mrs. Mathews*

Cost of Hospital Services

157. The actual financial experience of the fiscal year ended March 31, 1961 has been projected in direct proportion to expected population increase. The future position has been forecast in the light of current experience which may or may not prove to be consistent in the years ahead. This will, of course, vary in accordance with innovations and changes in the hospital field, as previously emphasized. Nevertheless, a reasonable estimate is provided of future cost if it were to prevail at present rates.

158. It is true, also, that such factors as inflation and internal quantity and quality improvement have brought increased cost of hospital services, in the past. An estimate of the increased cost in this regard has also been provided, making the basic assumption that this rate of increase could be the same in relation to population growth as it was estimated to be for the ten years ended 1960 in a Canada-wide study reported by the Department of National Health and Welfare. The state of the economy is subject to much change but it would seem reasonable to allow for some increase in cost in this regard and the trends if they continue could be rather startling, as indicated in the schedule. Every effort will have to be made to control the upward spiral in these costs, keeping in mind the welfare of the patient, at all times.

Hospital Construction and Capital Debt

159. The estimates made are a purely quantitative computation, based primarily on future population estimates but having some regard for the following:

- (1) The possibility of obsolescence of many of the physical units in the next 20 years.
- (2) The influence of improved transportation on the centralization of hospital services, resulting in an increase in hospital bed capacity in major centres, which is more than proportionate to the population increase in these areas. Similarly there may not be too much change in the type of service to be provided in the low population areas.

- (3) Technological advancement in equipment which may affect hospital construction.
- (4) The presently projected rates of number of beds per 1,000 population appear to be adequate and not in excess of present requirements.
- (5) The capital debt position regarding hospital construction stood at \$45,615,170 on March 31, 1961. Having regard to future needs this may be in the neighborhood of \$70,000,000 ten to twenty years hence, when allowance is made for its decrease by repayment in the foreseeable future and its increase by new construction.

PROJECTIONS OF HOSPITALIZATION EXPERIENCE FOR
ROYAL COMMISSION ON HEALTH SERVICES

Year	1961				1971				1976				1981			
Projected Population	1,313,000				1,531,000				1,691,000				1,867,000			
Percentage of 1961 Population	100.0%				116.6%				128.8%				142.2%			
Hospital Beds	Total Number		Per 1,000 Population		Total Number		Per 1,000 Population		Total Number		Per 1,000 Population		Total Number		Per 1,000 Population	
	Beds	Cribs	Beds	Cribs	Beds	Cribs	Beds	Cribs	Beds	Cribs	Beds	Cribs	Beds	Cribs	Beds	Cribs
General Hospital Beds	7,749	1,516	5.90	1.15 ⁽¹⁾	9,186	1,684	6.0	1.1 ⁽¹⁾	10,146	1,860	6.0	1.1	11,202	2,054	6.0	1.1
Auxiliary Hospital Beds ⁽²⁾	998	-	.76	-	3,062	-	2.0	-	3,382	-	2.0	-	3,734	-	2.0	-
TOTAL	8,747	1,516	6.66	1.15	12,248	1,684	8.0	1.1	13,528	1,860	8.0	1.1	14,936	2,054	8.0	1.1
Federal Hospital Beds ⁽²⁾	882	23	.67	.02												
Total Beds Including Federal	9,629	1,539	7.33	1.17												

(1) Birth Rate is expected to show a slight decrease according to Alberta Bureau of Statistics.

(2) Federal Beds have not been projected as these do not fall within the scope of our responsibility for planning.

General and Auxiliary Hospital Personnel	Total Number			Per Rated Bed ⁽³⁾		Total Number			Per Rated Bed		Total Number			Per Rated Bed		Total Number			Per Rated Bed	
	Gen-eral	Auxi-liary	Total ⁽³⁾	Gen-eral	Auxi-liary	Gen-eral	Auxi-liary	Total	Gen-eral	Auxi-liary	Gen-eral	Auxi-liary	Total	Gen-eral	Auxi-liary	Gen-eral	Auxi-liary	Total	Gen-eral	Auxi-liary
Nursing Staff	6988	381	7369	.92	.57	8451	1745	10196	.92	.57	9334	1928	11262	.92	.57	10306	2128	12434	.92	.57
Other Professional & Technical Personnel	675	13	688	.09	.02	827	61	888	.09	.02	913	68	981	.09	.02	1008	75	1083	.09	.02
Medical Staff	259	-	259	.03	-	276	-	276	.03	-	304	-	304	.03	-	336	-	336	.03	-
Other Personnel	4526	226	4752	.59	.34	5420	1041	6461	.59	.34	5986	1150	7136	.59	.34	6609	1270	7879	.59	.34
TOTAL	12448	620	13068	1.63	.93	14974	2847	17821	1.63	.93	16537	3146	19683	1.63	.93	18259	3473	21732	1.63	.93

(3) December 31, 1960 Figures.

Cost of Hospital Services Per Year

Operating Cost Payments (General and Auxiliary Hospitals & Nursing Homes) ⁽⁴⁾	\$37,266,263	\$46,286,018	\$51,128,979	\$ 56,448,298
Renovations ⁽⁴⁾	639,976	746,212	824,289	910,046
Equipment (General & Auxiliary Hospitals) ⁽⁴⁾	2,451,092	3,056,838	3,376,679	3,727,981
Projection for Population & Bed Increase	\$40,357,331	\$50,089,068	\$55,329,947	\$ 61,086,325
Additional Cost Increase ⁽⁵⁾	-	17,418,224	30,219,569	44,280,064
TOTAL	\$40,357,331	\$67,507,292	\$85,549,516	\$105,366,389
Capital Debt (General & Auxiliary Hospitals) ⁽⁶⁾	4,059,339	6,000,000	6,000,000	6,000,000
Total Cost Per Annum	\$44,416,670	\$73,507,292	\$91,549,516	\$111,366,389

(4) Projected for population increase with the increase in ratio of auxiliary hospital beds per capita being further weighted for the increased utilization.

(5) Hospital Care in Canada, March, 1960, attributes the increased cost of hospital care in Canada over the past ten years to four factors: 40% to the change in the value of the dollar; 25% to Population growth; 25% to internal quantity and quality improvement; and 10% to increased utilization rates, largely by people who needed hospitalization prior to hospital plans but were unable to use hospitals for financial reasons. (Published by Department of National Health and Welfare).

These factors have been applied here by: (a) disregarding the 10% factor for increased utilization rates.

(b) using the ratio of 40 units of increase due to dollar inflation, and 25 units of increase due to internal quantity and quality improvement to each 25 units of increase due to population growth (i.e. 2.6 x cost increase due to population growth).

(6) Estimated future annual debt cost is expected to be between 6 and 7 millions of dollars.

Hospital Construction Grants per bed are not included in any of these estimates. These would be paid as the construction is undertaken and could amount to a maximum of \$4,000 per bed at present grant rates, in addition to above costs.

C. TREATMENT SERVICES - SPECIAL

VIII. Division of Mental Health

C. TREATMENT SERVICES - SPECIAL

VIII. Division of Mental Health Services

161. The existing mental hospital facilities for the diagnosis, treatment and care of the mentally ill consist of two reception and active treatment hospitals, namely - Provincial Mental Institute, Edmonton, and Provincial Mental Hospital, Ponoka, and three continued care hospitals, namely - Provincial Auxiliary Mental Hospital, Claresholm, Provincial Auxiliary Mental Hospital, Raymond, and Rosehaven (for seniles), Camrose.

162. The province is divided on a population basis into northern and southern areas; patients are admitted to the Provincial Mental Institute, Edmonton, from the northern area and patients are admitted to the Provincial Mental Hospital, Ponoka, from the southern area.

The Reception and Active Treatment Hospitals

163. The Provincial Mental Institute, Edmonton, has a bed capacity of 1,550 and provides complete diagnostic, treatment and continued care services. This hospital also has a unit for the treatment and care of the tuberculous mentally ill from all areas of the province. A three-year training course is given to suitable men and women applicants who receive a certificate in psychiatric nursing upon successful completion of the course. Nurses in training in the general hospitals in the northern half of the province spend two months each in affiliation at this hospital.

164. The admission rate is high, approximately 1,000 per annum. The discharge rate is approximately 80 per cent. While the staff establishment as permitted in annual estimates is generally satisfactory, there is a marked shortage of available trained staff at all levels, that is, psychiatrists, nurses, psychologists, social workers, occupational therapists and various other categories. Insufficient trained staff hampers adequate rehabilitation services. Some out-patient service is provided to those who seek it. Attempts are made to provide a consultative service in the City of Edmonton for discharged patients and relatives. A few patients are provided with day-time or night-time care.

*Voluntary Assoc.
C.M.H.A. J. White
\$10,000 a year
Cdn. Govt.*

165. The geographical and population area served by the Provincial Mental Institute, Edmonton, is admittedly too large and poses the question of additional hospital service in the area to the north - for instance in the Peace River and far north. This hospital admits patients from the Yukon and the North-West Territories. It is felt that no additional beds be added to this hospital, but renovations of existing buildings should be continued.

166. There is an urgent demand for the admission of senile patients showing mental symptoms which is a serious demand on the services of a reception and active treatment hospital.

167. The Provincial Mental Hospital, Ponoka, has a bed capacity of 1,272 and provides complete diagnostic, treatment and continued care services. The admission rate is high - approximately 1,000 per year. The discharge rate is approximately 80 per cent. This hospital serves the southern half of the province's population. Provision is made for a medical staff of 15, including the Medical Superintendent and Assistant Medical Superintendent. There are seven certified psychiatrists and three experienced but uncertified medical officers. The general shortage of trained psychiatrists makes it impossible to fill the available vacancies. There is an acute shortage of trained psychologists and social workers, which hampers certain therapeutic procedures and rehabilitation efforts. While the nursing staff establishment of this hospital compares more than favourably with similar hospitals, there is always a shortage of well trained nurses.

168. This hospital provides a variety of nurses' training courses. A four-year course is offered leading to diploma in general and psychiatric nursing. A three-year course is offered to male staff members, leading to a certificate in psychiatric nursing. A six-month psychiatric nursing course is provided for graduate nurses. All nurses in the general hospital training programs in the southern half of the province affiliate in this hospital for two months during their course. Great difficulty is experienced in keeping the posts of Instructors of Nursing up to full strength. The various training schemes have resulted in a high standard of nursing care, both general

and psychiatric.

169. Since the geographical and population area of the province served by this hospital is extensive and widely separated, it is felt a psychiatric hospital is needed in the Calgary area. It is recommended that no additional beds be added to the Provincial Mental Hospital, Ponoka, but that renovations of certain areas should be continued.

170. As in the case of the Provincial Mental Institute, Edmonton, there is an urgent demand for the admission of senile patients showing mental symptoms, which creates a great demand on the services otherwise designed for the active treatment of psychotic patients.

171. This hospital provides an out-patient service for the Ponoka area and a Guidance Clinic Service in a radius of fifty miles. A psychiatrist from the hospital visits the City of Calgary one day each week and sees discharged hospital cases by appointment, to give advice and review medications.

Existing Facilities for the Care of Emotionally Disturbed Children

172. Linden House, Red Deer, has a bed capacity of thirty, designed for fifteen males and fifteen females. It came into being as a pilot project on which to base future opinions as to the needs for the care and treatment of emotionally disturbed children. It has been in operation for two years and a review of the activities of the institution is planned for in the immediate future. Such information as may be gleaned relative to staff requirements and treatment methods should prove valuable in the planning of facilities in the future.

173. To date it would appear there is a preponderance of demands for the admission of male children to this facility. Thirty-nine children have been admitted (25 male, 14 female) since the opening of the unit. Ten children were discharged as recovered from their disturbances, eight were absorbed into the various institutions in the Division of Mental Health, the remainder are still under treatment and supervision.

174. Efforts have been made to study various tech-

niques of handling the children, since no fixed recognized methods have been established elsewhere. The professional and other staff members have been drawn from the Provincial Training School resources. Many of the staff are graduates of the Mental Deficiency Nursing Course of that institution.

Emotionally Disturbed Children's Unit, University Hospital, Edmonton
175.

A unit of eight beds for emotionally disturbed children is operated under the aegis of the Department of Psychiatry in the University of Alberta Hospital. It is reported this is an inadequate number of beds to satisfy the needs and demands.

Auxiliary Mental Hospitals

176. The Provincial Auxiliary Mental Hospital at Claresholm, Alberta, has been in existence since 1933, with a fixed population of 100 women patients. All patients were transferred there from the Provincial Mental Hospital, Ponoka. The patients have been long-standing cases which have not responded to treatment. Many are now senile and many were mental defectives. All defectives have since been removed from the hospital. At the moment of writing, new facilities for expansion of this hospital have been developed and the patient population will be increased to approximately 300, immediately. Two additional patient units will be added to bring the patient population up to a maximum of 500 or less. The patient population will be built up by the transfer of patients to this institution from the Provincial Mental Hospital, Ponoka, and the Provincial Mental Institute, Edmonton. Patients who have formerly been resident in the south of the province will be given precedence for transfer to this hospital and others whose relatives reside in the southern area of the province will be included among the transfers.

177. The role of this hospital in the future will probably be to absorb the long term cases from the Provincial Mental Hospital, Ponoka, and also similar cases which may accrue from a projected new Mental Hospital facility in the City of Calgary.

178. The Provincial Auxiliary Mental Hospital, Raymond, has a constant population of approximately 130 female

patients. The latter have been transferred from the Provincial Mental Hospital, Ponoka, almost exclusively. The hospital provides long term care and the patients are largely in the senile group. Medical care is provided by a medical clinic in the nearby Town of Raymond.

179. "Rosehaven", Camrose, is in effect, a mental hospital for the aged mentally ill who are admitted by transfer from the Provincial Mental Institute, Edmonton, and the Provincial Mental Hospital, Ponoka. The patient population of men and women numbers 510. This institution serves a very useful purpose in the network of provincial mental institutions, in permitting of an outlet of senile patients from the two active treatment hospitals. Notwithstanding this, the admission rate of seniles to the parent hospitals is so excessive as to result in an ever-increasing number of seniles accumulating in these hospitals. A conservative estimate of the number of senile patients in all mental institutions would be 1,000. Of these, 510 are in Rosehaven, some 46 are in the Provincial Auxiliary Mental Hospital at Claresholm, and 68 are in the Provincial Auxiliary Mental Hospital at Raymond. The balance - some 400 - are resident in the parent mental hospitals.

Other Psychiatric Services

180. A psychiatric service of some 70 beds is operated under the aegis of the Department of Psychiatry in the University Hospital, Edmonton. An out-patient service is also provided in this department. These psychiatric services are partially subsidized by the provincial government on a basis of bed occupancy.

181. A psychiatric service of about 30 beds is provided by the Calgary General Hospital. All psychiatric patients are treated in this unit by psychiatrists in private practice in the City of Calgary. This service is also subsidized by the provincial government on a basis of bed occupancy.

METHODS OF IMPROVING EXISTING FACILITIES

Mental Hospitals

182. Structural Facilities: These facilities are

reasonably good at the present moment as a result of persistent efforts to provide new buildings, renovate certain impractical old structures and keep up a high standard of maintenance.

183. There is need in the future for an active treatment in-patient service in the Calgary area and the establishment of these services should be accomplished as soon as possible.

184. A growing need for facilities in the Peace River and Lethbridge areas must soon be taken into consideration.

GERIATRIC SERVICES

185. A situation has arisen as a result of the constant pressure on the active mental treatment hospitals to assume the care of patients categorized as senile or arteriosclerotic. A conservative estimate of the number of beds now occupied in the Provincial Mental Hospital and the Provincial Mental Institute each, is 15 to 20 per cent. This is a severe drain on the resources of these hospitals. This fact points up the urgent need for the extension of the geriatric services, either by creating more institutions such as Rosehaven, within the Mental Health Services proper, or the establishment of a somewhat autonomous geriatric service in its own right. This would go a long way to reduce the active mental hospital services to their proper psychiatric function, that is, treatment and rehabilitation, and continuous efforts to prevent hopeless chronicity. The Provincial Auxiliary Mental Hospital, Claresholm, is being enlarged to accommodate some 500 patients and it now appears this institution will have to take on the function of a geriatric service.

Wasn't this the intention from the start.

Psychiatric Services in General Hospitals

186. The Division of Mental Health supports the viewpoint that there should be an adequate number of beds in general hospitals assigned for psychiatric care - approximately 10 to 15 per cent of the hospital's bed capacity.

EXISTING INSTITUTIONS FOR MENTAL DEFECTIVES

187. The existing institutions for the care of mental defectives consist of: The Provincial Training School, Red Deer, and Deerhome at Red Deer.

188. The Provincial Training School, Red Deer, has approximately 850 beds where children who are educable, trainable and chronically disabled are admitted. Providing no physical or temperamental instability exists, nearly all trainees from the high-grade imbeciles to the borderline defectives are discharged at approximately the end of the second decade of their lives. Jobs are found for them in the normal community and the social service department of the Training School continues to check their welfare, financial matters and general happiness in their placements.

189. The Training School conducts a three-year course in Mental Deficiency Nursing. This provides a nucleus of trained staff at all times. There is no constant supply of trained nurses from elsewhere.

190. The structural facilities of this institution are excellent. There are twelve classrooms for sense training and school instruction. There are facilities for vocational training as well as a farm on which many of the trainees work under the instruction of a trained agriculturist. The calibre of the care, instruction and treatment of the school population is undoubtedly superior to the best found in any similar institution.

191. Deerhome, Red Deer, is an institution designed for the long-term care of adult mental defectives. It also cares for a number of young, infirm cases. The present patient population is 885. A new unit is ready for occupancy and will take care of another 150 or more patients. There is provision for the addition of two more units to accommodate 300 more patients, bringing the total to about 1,300. The bulk of the patients were evacuated and transferred to Deerhome from the Mental Hospitals and the Provincial Training School.

192. Although Deerhome is largely a custodial institution, a goodly number of discharges have been effected. Furthermore, several hundred of the patients engage in useful occupation in the institution, and a similar number work part-time in the nearby City of Red Deer. This is a new institution and the structural facilities are excellent. For all practical purposes, Deerhome has relieved the mental hospitals of the need for the admission of mental defectives to

them, even in the cases of those who might be showing some psychotic manifestations.

FUTURE NEEDS RELATIVE TO THE CARE OF MENTAL DEFECTIVES

193. The Provincial Department of Education has been assuming more and more the responsibility for the education of uncomplicated cases of mental retardation. Over and above the aforementioned provisions, certain private schools have sprung up, chiefly in the cities, for the education and vocational training of the mentally retarded. These have been supported in part by the Department of Education.

194. Authorities estimate there is a defective population in the ratio of 100 to 150 persons out of every 1,000 children born yearly, comprised of (1) Intellectual Inadequacy, (2) Familio Hereditary types, (3) Mutant Abnormalities, (4) Metabolic Disorders, and (5) Neurological Disease or Injury. The birth rate of Alberta is approximately 35,000 per year. Of these some 4,000 will be defective and 25 per cent of the 4,000 - or 1,000 - will require special education and institutional care. ^{how many?} This indicates the magnitude of this problem alone. } ?!

195. The Provincial Training School at Red Deer has a bed capacity of some 800, with provision for the construction of another unit which will bring the population up to about 1,000. The demand for admission to the Training School is in excess of the supply of beds. This poses the question of the establishment of another such institution, possibly in the Edmonton area.

196. Deerhome, the institution for adult and infirm-ary care of defectives, is planned for two more patient units which will bring its bed capacity to approximately 1,300. Future population demands for more beds will result in the necessity for another institution of this type.

PREDICTIONS OF INCREASE IN THE NUMBER OF ADDITIONAL INSTITUTIONAL BEDS REQUIRED ON THE BASIS OF THE INCREASING POPULATION

197. These predictions are based on experience to the effect that 125 extra beds are required annually, to take care of such increases in the patient population of mental hospitals, and 100 extra

beds are required annually to take care of the increase in the patient population of institutions for mental defectives.

198. In the case of beds for the emotionally disturbed and the adolescent units, predictions cannot be made on experience to date in these fields.

199. EXTENSION OF MENTAL HOSPITAL SERVICES

PERIOD	Additional Beds Required on Basis 125 per year	Cost per Bed \$5,000	Total Number Beds (approx.) in all Psychiatric Hospitals
1961 - 1971	1,250	\$6,250,000.00	4,500
1971 - 1976	625	\$3,125,000.00	5,125
1976 - 1981	625	\$3,125,000.00	5,750

200. EXTENSION OF MENTAL DEFECTIVE SERVICES

PERIOD	Additional Beds Required on Basis of 100 per year	Cost per Bed \$5,000	Total Number Beds
1961 - 1971	1,000	\$5,000,000.00	2,750
1971 - 1976	500	\$2,500,000.00	3,250
1976 - 1981	500	\$2,500,000.00	3,750

PREVENTIVE SERVICES - GUIDANCE CLINICS

201. EXISTING FACILITIES:

The Provincial Guidance Clinic, Edmonton

The Provincial Guidance Clinic, Calgary

The Provincial Guidance Clinic, Lethbridge

The Provincial Guidance Clinic, Medicine Hat
(Branch of the Lethbridge Clinic)

The Provincial Guidance Clinic, Red Deer
(Services by staff of Provincial Training
School)

The Provincial Guidance Clinic, Ponoka
(Services by staff of the Provincial
Mental Hospital)

202. The Provincial Guidance Clinic, Edmonton - The staff of this Clinic is comprised of two certificated psychiatrists, two non-certificated psychiatrists, one part-time certificated psychiatrist, six psychologists, six social workers.

203. The case-referring agencies are schools, medical practitioners, medical clinics, welfare agencies, juvenile and family courts, parents and others. The diagnostic categories are: (1) Educational Problems, (2) Intellectual Inadequacy, (3) Emotional Disorders, (4) Anti-Social Behaviour, (5) Psychoses and Psychoneuroses, (6) Others. The age groupings are as follows, approximately, by percentages: 0 to four years of age - 10 per cent; five to nine years of age - 42 per cent; ten to fourteen years of age - 30 per cent; fifteen to nineteen years of age - 13 per cent; twenty and over - 3 per cent.

204. The Clinic serves the City of Edmonton and the northern half of the Province's population, including the Peace River area. The demands for increased service are great and treatment of an organized nature is not possible for cases beyond the area of Metropolitan Edmonton. There is always a back-log of cases to be seen.

205. In addition to the routine case-work, the Clinic gives much in-service training to its professional staff. The Clinic is recognized by the Royal College of Physicians and Surgeons of Canada as a training centre for one year of psychiatric training.

206. The Clinic carries out an extensive public education program of panels, lectures, radio and television appearances.

207. Great difficulty is experienced in obtaining the services of professional staff in all categories - (psychiatrists, psychologists and social workers).

208. The Provincial Guidance Clinic, Calgary - The staff of this Clinic is composed of the following: Two psychiatrists; four psychologists; one part-time psychologist; and four social workers. The case-referring agencies are similar to those applicable to the Provincial Guidance Clinic in Edmonton. The diagnostic categories seen are similar to those of the Edmonton Clinic, also; and the age groupings are roughly similar to the Edmonton Clinic.

209. The Clinic serves the City of Calgary and an

*What is the case load in each clinic
What is approx cost of such services if paid by govt to private sources of help.*

area approximately 100 miles in radius. The demands on the Calgary Clinic are also very great and treatment of an organized nature is not possible beyond the area of metropolitan Calgary. There is always a back-log of cases to be seen.

210. The Clinic carries out extensive public education programs, also much in-service training of professional staff members. Great difficulty is experienced in obtaining the services of professional staff in all categories.

211. The Provincial Guidance Clinic, Lethbridge - When at full strength this Clinic has the following staff: One psychiatrist, two psychologists, and two social workers. This Clinic operates in a similar manner to the Edmonton and Calgary Clinics; it serves the Lethbridge area and an area 100 miles in radius, which includes the Medicine Hat area. Treatment is possible only in the metropolitan area of Lethbridge, and in the Medicine Hat area where there is a branch office of the Lethbridge Clinic.

212. While the age groupings of the cases are somewhat similar to the other Guidance Clinics, more adults are seen proportionately, doubtless due to the fact that there are no psychiatrists in practice in the area served by the Clinic. The same difficulty exists in obtaining the services of trained and experienced personnel, namely - psychologists and social workers - and the work of this Clinic is hampered because of this.

213. The Medicine Hat Branch of the Provincial Guidance Clinic, Lethbridge - The staff of this branch is comprised of a social worker. The branch works in close liaison with the parent Clinic in Lethbridge. It carries out as much as possible of the ground work of the cases referred to it from the area surrounding Medicine Hat. Cases are treated under the supervision of the psychiatrist of the Lethbridge Guidance Clinic.

214. The Provincial Guidance Clinic, Red Deer - This is a part-time Guidance Clinic, with the work being carried out by a team consisting of a psychiatrist, psychologist and social worker from the Provincial Training School. The Clinic functions in a similar manner to the other Clinics. The area served is roughly

fifty miles in radius. Some treatment is provided.

215. " Provincial Guidance Clinic, Ponoka - A Clinic team comprised of professional staff members (psychiatrist, social worker and psychologist) from the Provincial Mental Hospital, Ponoka, sees cases at the Provincial Mental Hospital and serves an area including and surrounding the Town of Ponoka. While this Clinic team gives good service to the area involved, the establishment of a fully staffed Guidance Clinic in the City of Red Deer would do much to provide the necessary service in the Red Deer and surrounding areas.

METHODS OF IMPROVING EXISTING PREVENTIVE AND GUIDANCE CLINIC SERVICES

216. Experience of over 30 years in the operation of Guidance or Mental Health Clinics, has revealed much on the basis of which recommendations can be made.

Structural Facilities

There must be adequate office and treatment areas in all Clinics. This can only be determined on a basis of actual case-load at any given time and is directly related to the population of the area served. It is very important that the structural facilities be suitably located, affording parking areas for personnel and clientele. Ground-level facilities are highly desirable. Carefully planning is necessary in relation to the floor space and the specific purposes for which it is to be used. The Clinics should be geographically situated, where possible, in the vicinity of other health services, such as hospitals and various other Clinics. It would be desirable from a standpoint of utilization of University facilities - including Research resources - to have Clinics established in the vicinity of the University.

217. Experience has shown that a percentage of cases seen will require in-hospital observation, investigation and treatment. To this end, provision should be made for the erection of in-patient facilities which would include, as well, day or night care. Guidance Clinics could be established in areas set aside for them in such structures. Included in the set-up would be provision and areas for

Researchers or Research teams.

218. On a basis of the number of cases, particularly of emotional disturbance in children being seen in the entire Provincial Guidance Clinic Service, two such facilities, one in Edmonton and one in Calgary, each capable of handling 40 to 50 residential cases, are considered highly desirable.

219. Over the years the Clinics have been called upon to deal with many adolescent cases, presenting various problems, including anti-social behaviour. These cases are not patients who are "delinquent" exclusively, within the meaning of the term. They are patients who, in the opinion of the Guidance staff, are treatable - such treatment being possible only on an out-patient and in-patient basis. While some authorities may feel such cases often can be, and are treated successfully in mental hospitals, either in separate wards set aside for them, or in the usual hospital population, the Clinic staff recommend separate facilities, accessible to Clinic personnel. The consensus is that two such institutions of special design, are required in Alberta, each institution to have a capacity of 40 to 50 beds.

Staffing

220. Adequate staffing of the Clinics with trained and experienced psychiatrist, psychologists and social workers, is a "must". The critical shortage of such staff has plagued the Guidance Clinics throughout the years.

Training Centre for Psychiatrists

221. Training Centres for Psychiatrists have been developed on a Canada-wide basis since the 1st war, but only recently has stress been laid on child psychiatry. The centres have not been able to provide trained psychiatrists in suitable numbers for Mental Health Clinic purposes.

Psychologists

222. Well-trained and experienced psychologists for Guidance Clinic work have never been available in sufficient numbers. It has been necessary to engage the services of recent University

graduates - most of whom have been at the B.A. level, and who require much in-service training. The acute shortage applies to all Clinics and Psychiatric facilities. The greatest hope for improvement in the supply would lie in increased University facilities for giving advanced training to a greater number of selected graduates. Guidance Clinics are greatly hampered by a lack of properly trained and experienced psychologists who can administer the various psychological tests, and participate in the Clinic treatment program under the direction, and in association with, the Clinic Psychiatrist. Much valuable time of the senior staff members is devoted to the in-service training of junior psychologists.

Social Workers

223. In this field there is also an acute shortage of adequately trained and experienced workers. Their services to the Clinics are indispensable. The Clinics have been obliged to engage recent graduates at the B.A. level, and give intensive in-service training to them. Again this diminishes the effectiveness of the Clinic in keeping up with its patient demands. There is no School of Social Work at the University of Alberta, and the consensus is that one is badly needed to ensure in part a constant supply of Workers, not only in the Clinics, but in the psychiatric facilities in the Province. It is felt that Alberta students who are obliged to go to other provinces for training in Social Work, feel little obligation or inclination to return to Alberta to render service here.

224. EXTENSION OF PROVINCIAL GUIDANCE CLINIC SERVICES

The Provincial Population in 1961 was 1,313,000	Estimated Annual Cost	1971 Provincial Population 1,531,000	1976 Provincial Population 1,691,000	1981 Provincial Population 1,867,000
Edmonton Area	\$125,000.00	\$250,000.00	\$300,000.00	\$ 375,000.00
Calgary Area	100,000.00	200,000.00	250,000.00	300,000.00
Lethbridge Area	40,000.00	100,000.00	125,000.00	150,000.00
Medicine Hat Area	7,000.00	20,000.00	30,000.00	40,000.00
Red Deer Area	22,000.00	40,000.00	50,000.00	75,000.00
Grande Prairie Area	---	40,000.00	50,000.00	75,000.00
T o t a l	\$294,000.00	\$650,000.00	\$805,000.00	\$1,015,000.00

C. TREATMENT SERVICES - SPECIAL

IX. Division of Tuberculosis Control

IX. Division of Tuberculosis Control(1) Facilities

225. There are at the present time in the Baker and Aberhart Sanatoria in which total care is provided by the Province without any charge to the patient, a sufficient number of treatment beds (550) available for all patients with active tuberculosis in the Province. Should the present trend continue, the need of additional new accommodation is unlikely, with the two Provincial Sanatoria now showing an average occupancy of about 65 per cent.

How many pths. are treated each year -

(2) Prevention

226. Prevention is stressed by early diagnosis to reduce the period of infectivity among relatives and associates. X-ray and tuberculin testing surveys - Hospital admission x-ray program in 38 hospitals - also in Provincial Gaols - the Unemployment Commission Building and the City Halls in Lethbridge, Calgary and Edmonton. Numerous smaller hospitals use tuberculin testing of all admissions and then x-ray the positive reactors. Stationary clinics are held twice weekly in both Calgary and Edmonton Sanatoria for clinical assessment of contacts, ex-sanatorium patients and any suspects referred by practicing physicians. There are also six other stationary clinics in larger centres in the Province.

(3) Treatment

227. All active cases are advised to be admitted into a Sanatorium for complete evaluation, the establishment of adequate therapy and to provide isolation and care while the patient is in the acute and probably infectious state.

228. All necessary surgical care is provided as required in the Sanatoria for all pulmonary and non-pulmonary cases of tuberculosis. Nearly all patients who are treated for active tuberculosis are requested upon discharge to continue drug therapy at home for varying periods of time - usually from six months to two years or longer. Proper follow-up and supply of drugs requires some continued supervision through the out-patient clinics - while in the patient's own locality considerable assistance can be given by the family doctor

and Public Health or School nurses to check and encourage patients to continue drug therapy.

229. There is some concern regarding the evident gradual increase in the number of patients who have strains of tubercle bacilli that are resistant to one or more of the three best antimicrobial drugs, while several other useful drugs are available, none as yet have proven to be as efficient. There is now a greater need to have patients who demonstrate such resistant strains to be treated and retained in a Sanatorium until they are non-infectious.

(4) Rehabilitation

230. As soon as a patient is admitted to Sanatorium and treatment begun - he is also assessed regarding his future work capabilities and a program outlined for rehabilitation if necessary, or for continuing study. The Alberta Tuberculosis Association assists both Sanatoria by having a Director of Rehabilitation in Edmonton and an assistant at each Sanatorium. They also employ a teacher at each institution to supervise Business courses - teach basic English and assist in completion of some High School subjects. The Department of Public Health supplies two full time teachers for academic subjects covering grades one to nine. The occupational therapist helps round out the rehabilitation program.

231. The past fourteen years has seen specific drug therapy used in the treatment of tuberculosis. Prolonged bed rest and the various procedures to collapse a diseased lung have largely disappeared. Patients are more ambulant - areas of disease resolve more quickly and sputum conversion with spontaneous closure of cavities occur more frequently - all these have shortened the period of infectivity and hence the length of stay in a Sanatorium. During the past ten years the latter has almost been cut in half, this in turn is equivalent to having almost twice as many beds for treatment and has made the length of drug therapy and supervision as out-patients twice as long.

232. The future program may require closer attention to the out-patient by the family physician - public health or school nurse - the patient would be best reporting to them every two to four

weeks to ensure that adequate therapy and a prescribed routine is followed. This will assist in prevention of resistant strains of tuberculosis developing and lessen the number of exacerbations requiring re-admission to Sanatorium.

233. It is now considered that about 20 - 25 per cent of our population are positive reactors to the tuberculin test - or in other words have been infected. I believe our future case finding program will need to use more tuberculin testing surveys of the public in conjunction with mass x-ray surveys. Eventually prevention may require every known non-reactor to the tuberculin test to have the test repeated yearly - while every positive reactor to the tuberculin test should have a chest x-ray yearly or at least every two years, the latter would include all ex-Sanatorium patients as well as known contacts.

234. As to the future requirements of personnel, there is no doubt that there should be a gradual reduction in the number of beds required and as this occurs contraction of attending staff may be expected - however, while hospital facilities and staff for patient care may continue to decline it would be dangerous to be lulled into a state of complacency as to the actual large number of tuberculous patients not in hospital that could become a menace to the unsuspecting public. In Canada the admissions to Sanatoria at present show one-third are re-admissions or have had previous treatment. The rate of reactivations among this group is twenty times greater than among the general population. It is understandable that clinic services must be maintained if not extended to ensure adequate post-Sanatorium therapy and follow-up during the life-time of all discharged patients.

235. One of the serious threats to our progress in tuberculosis control is the evident increase in both re-admission and newly discovered cases of tubercle bacilli which are resistant to our present drugs. This develops more frequently in patients whose treatment has been sporadic and improperly carried out. This points up the importance of a period of Sanatorium care to establish adequate therapy, to ensure the patient is non-infectious to others and to teach the patient the importance of continuous therapy for the prescribed period

upon discharge. This problem also stresses the need of new drugs to replace our present ones.

236. Due to the increasing out-patient work the future expenditure to carry out an effective control program cannot be reduced in proportion to bed occupancy in our Sanatoria. Any curtailment of our present diagnostic, treatment or follow-up services would probably invite a resurgence of tuberculosis, and the facilities in both Calgary and Edmonton will continue to be essential in the control program. This estimate is not based upon treatment beds alone but considers as well control centres for a very large surrounding population.

237. The future need of adequate medical services for tuberculosis work could be greatly assisted by a gradual use of empty beds by internists in medicine and especially chest diseases. Some of these men might be used on a part-time basis to assume some responsibility for the care of tuberculosis. This would enhance the interest of the medical profession generally in that this group in teaching undergraduates and post-graduates should increase the number who eventually might take a greater part in tuberculosis control and stimulate research not only in tuberculosis but in all respiratory diseases.

238. In projecting cost figures based upon approximate expenditure of \$2,000,000 in 1960 - and taking into consideration population growth figures for 1971 - 1976 and 1981 the two Sanatoria have been estimated separately. Since the use of drugs in the past fourteen years in Alberta the death rate for tuberculosis has dropped ^{what is it?} _{1951 - 1961 -} dramatically, while the notification rate increased until 1958, since then there has been a gradual decline. The goal set across Canada is that we may reduce the morbidity rate of 10 per cent per year and upon this basis a projected estimate of required Sanatorium beds for treatment has been made. The decrease mentioned may be possible for ten years and thereafter it is also possible that a plateau will be maintained for some years with a slower decrease. This is suggested due to the fact that a certain percentage of our infected population will continue to break down in the later years of their lives - and unless new drugs are discovered, resistant strains of tuberculosis may greatly

alter our estimates in ten years.

The Baker Memorial Sanatorium - Calgary

239. (a) In 1966 should manage with 100 treatment and diagnostic beds, and providing the remaining ones can be put to other use, to assume a share of the entire operation the cost for tuberculosis might be reduced from the 1960 figure by one-third.
- (b) In 1971 Baker Memorial Sanatorium may require 60 beds and a further reduction in cost from the 1966 figure of three-fifths.
- (c) 1976 estimate of 50 beds and a reduction in cost from the 1971 figure by one-sixth.
- (d) In 1981 providing we maintain the estimated decrease in new cases - diagnostic and clinic services with 35 treatment beds may be sufficient and costs again reduced from 1976 by seven-tenths.

The Aberhart Memorial Sanatorium - Edmonton

240. By 1966 it is estimated 200 beds may be required and providing the remaining 95 can assume their share of over-all cost by being used for medical cases and chest disease, the cost for tuberculosis from the 1960 figure might be reduced by almost one-third.

- (a) 1971 - Estimated beds required is 150 with a reduction in cost from the 1966 figure by one-quarter.
- (b) 1976 - Estimated 120 beds needed, with reduction in cost from 1971 figure by one-fifth.
- (c) 1981 - Estimated beds required is 85 - again a reduction in cost from the 1976 figure by about one-fourth.

241. There are so many factors which may affect the above estimates such as length of treatment in Sanatorium, availability of new drugs, resistant strains of tubercle bacilli - efficiency of out-patient treatment, maintenance of adequate clinic and diagnostic services. The latter must of necessity form the spear-head and be increased if deemed essential to ensure progress in control of tuberculosis.

C. TREATMENT SERVICES - SPECIAL

X. Poliomyelitis Treatment Program

X. Poliomyelitis Treatment Program

242. The Poliomyelitis Sufferer's Act and Regulations make provision for treatment services for residents of Alberta who suffer from poliomyelitis and its subsequent effects without cost to the patient. These treatment services include all necessary hospital, medical and surgical care. Orthopaedic appliances are provided. Out-patient physiotherapy, muscle tests, and radiological examinations and other assessment procedures are available. Out-patient speech therapy and occupational therapy are provided. In 1960 there were 304 new admissions and 172 re-admissions, making a total of 476 patients.

243. Monies expended in the poliomyelitis treatment and prevention program amounted to over \$125,000.00 for the year 1960.

C. TREATMENT SERVICES - SPECIAL

XI. Cerebral Palsy Clinics

X1. Cerebral Palsy Clinics

244. The Province of Alberta maintains Cerebral Palsy Clinics in Calgary and Edmonton.

245. The treatment of cerebral palsy, a very old disease, is relatively a new science and therefore a rapidly changing one. Treatment embraces physiotherapy, bracing, speech therapy and education.

246. It has become increasingly evident that to function economically treatment facilities should largely be reserved for those children who have the mental ability to be educated. The clinics have used the services of the Provincial Guidance Clinics in determining the mental status of all patients prior to admission for treatment in the clinics.

247. In 1961 the estimated expenditure was \$100,000.00 per year. In 1971, when the population has increased approximately 7 per cent, the cost of this service should rise to approximately \$130,000.00. This is more than a 7 per cent increase in cost but it is felt this increase will be necessary as at the present time the clinics are working at about actual capacity and, therefore, further staff is going to be required to level this off. In 1976 a further increase of 7 per cent would bring this to a cost of \$150,000.00 and by 1981 the cost should have risen to \$170,000.00.

248. It is understood that the birth rate of cerebral palsy children has remained at a pretty constant level of 7 per 100,000 general population and consequently the above figures can be expressed as fairly accurate as far as this disease is concerned. If the government were to expand their services to include the cerebral palsies who are mentally retarded to a severe degree, or if it were to expand its services to provide rehabilitation into sheltered industry for the older age group of cerebral palsies, these expenditures would be increased.

249. In Alberta the cost, including domiciliary care for a certain percentage of cerebral palsy children, is estimated to be \$1,500.00 per patient at the present time. In order to estimate the costs of any program it is necessary to assume that all children

receiving treatment at this centre would be in-patients. The in-patient domiciliary care will approximately double the present per patient annual cost to \$3,000.00 per patient. In the centre for multiple handicapped children it is calculated there will be about two hundred children treated daily, and this number multiplied by \$3,000.00, the cost per child per year, would bring the expenditure to \$600,000 per year in 1963.

250. With population increases it can be estimated that this cost will reach a level of \$700,000.00 by 1971, \$850,000.00 by 1976, and somewhere in the vicinity of one million dollars in 1981.

251. These figures are undoubtedly startling. On the other hand, the larger centers in the United States estimate somewhere between \$4,000.00 and \$8,000.00 per patient per year. A typical example of this is the Institute for Cerebral Palsy in Maryland where the cost is approximately \$8,000.00 per patient per year.

C. TREATMENT SERVICES - SPECIAL

XII. Rheumatoid Arthritis

XII. Rheumatoid Arthritis

252. The Department of Public Health has made provision for the treatment of persons under the age of twenty-five years suffering from Rheumatoid Arthritis without charge to the patient.

253. Clinics are maintained in Calgary and in Edmonton and residents of the province under twenty-five years may be seen on the referral of their own physicians.

254. Patients are assessed in the clinics, treatment is instituted, and when necessary the patient is admitted to hospital for further assessment and treatment.

255. From the cases treated it is apparent that adequate early treatment is reducing long hospital stay and a degree of permanent disability.

256. It is also noted that the majority of patients who have reached the age of ineligibility are not requiring long hospitalization because they have reached the stage of stability which permits them to maintain routines at their homes under their private physicians.

257. It is thus found that early and active care of the rheumatoid arthritic youngster reduces the over-all cost to society.

258. The clinics provide new chemical agents for the treatment of rheumatoid arthritis when their value and need has been established. These, however, are considered only as a useful adjunct to the basic treatments in rheumatoid arthritis.

259. The basic treatment consists of educating the patient in following more simple routines involving rest, exercises and physiotherapy.

260. Eighteen new cases of rheumatoid arthritis were treated in 1960 and a total of 106 cases are under care at the present time. The total number of days in hospital for assessment and treatment amounted to 1,198.

C. TREATMENT SERVICES - SPECIAL

XIII. Division of Cancer Services

XIII. Division of Cancer Services

261. Cancer services are provided by the Province under The Cancer Treatment and Prevention Act and Regulations. The purpose of this program is to make available to the residents of the Province a high quality of cancer diagnostic and treatment service without charge to the patient.

262. There are Cancer Clinics in Edmonton, Calgary, and Lethbridge. These clinics are for the purpose of ascertaining the presence or absence of cancer, the evaluating of the form of treatment and either to direct the treatment or act as consultants to the surgeon providing treatment. There are highly trained therapists and diagnosticians in charge at these clinics together with a large group of consultants available to act in an advisory capacity.

263. When cancer is diagnosed the clinic staff assess the case and recommend the form of treatment. The services available to a patient through the clinics at no cost are as follows:- Diagnostic examination, laboratory tests, radiological diagnostic services, consultation services, endoscopy examinations, diagnostic curettages, exploratory laparotomies and biopsies, surgery, therapeutic radiology, radium, cobalt and cesium therapy and chemotherapy. Surgery is also paid for when malignancy is proven during certain surgical procedures on a post-operative basis providing the surgeon reports the case to a Cancer Clinic. The radiotherapy services are provided only through the clinics at Edmonton and Calgary, while the chemotherapy and surgery may be provided at the hospitals in cities where the clinics are established or the patient may return to his own surgeon or physician for treatment as recommended by the clinics. The diagnostic records and recommendations of the consultant staff accompanies these patients to their physician or surgeon.

264. The patient's co-insurance charges covering hospitalization during any diagnostic period is also paid for by the Department to a maximum of seven days. Diagnostic examination and tests by the patient's own doctor may be approved, provided all operative and pathological reports are submitted to the clinic. Approval is also given for emergency surgery only when the subsequent records

and reports provided by the surgeon indicate the emergency nature of the case.

265. As a result of the foregoing program, the residents of the Province have been provided with a high quality of cancer diagnostic and treatment service.

Number of Examinations made (Malignant and Benign) in 1959 & 1960

	<u>New</u>		<u>Review</u>		<u>Total</u>	
	<u>1960</u>	<u>1959</u>	<u>1960</u>	<u>1959</u>	<u>1960</u>	<u>1959</u>
Edmonton	2,816	2,859	10,739	9,114	13,555	11,973
Calgary	1,928	1,833	7,198	6,409	9,126	8,242
Lethbridge ..	569	522	1,468	1,338	2,037	1,860
			Total		<u>24,718</u>	<u>12,075</u>

266. The number of examinations made where malignancy was proven was 20,143 in 1960 as compared with 17,644 in 1959, as shown in the following table:

	<u>Edmonton</u>	<u>Calgary</u>	<u>Lethbridge</u>	<u>Total</u>
1960	10,994	7,597	1,552	20,143
1959	9,574	6,659	1,411	17,644

267. Number of cases provided with the following services in 1960 - Edmonton, Calgary and Lethbridge:-

Hospital Services	427
Radiation Therapy	2,272
Diagnostic X-Ray	9,232
Major Surgery	1,331
Exploratory Laparotomy	235
Breast Biopsies	646
Other Biopsies	1,176
Diagnostic Curettages	452
Encephalograms, etc.	18
Bronchoscopy and Oesophagoscopy	213
Sigmoidoscopy	214
Cystoscopy	472
Investigations & Consultations	214
Laboratory Tests	13,735

268. Every year during the past number of years there is an increase in the demand for services through the cancer clinics

with greater and greater demands on our diagnosticians and therapists. Due to this it appears desirable that a new clinic be built in Edmonton with increased diagnostic and therapy facilities and added therapy equipment in conjunction with in-patient facilities.

269. The cost of operating the cancer clinic services program for the year 1960/61 was \$1,008,000.00. Of this amount approximately \$750,000.00 is in relation to providing medical services (this item is made up of medical salaries, staff, medical fees for surgical services plus the cost of drugs provided).

270. If the above amounts had been absorbed the individual patients, it is estimated that the charges would have been in excess of \$825,000.00.

271. A projection of future costs would be difficult to make and if a break-through in this field occurs in the near future any projected figures could well be invalid. Past experience indicates, however, that approximately \$200,000.00 per year has been required to meet the ever increasing call on these services.

C. TREATMENT SERVICES - SPECIAL

XIV. Blood Transfusion Service

XIV. Blood Transfusion Service

272. A blood transfusion service is maintained in the province of Alberta which is maintained under the auspices of the Canadian Red Cross with assistance from the Government of the Province of Alberta. Transfusion centres are located in Edmonton and Calgary. The blood transfusion service is maintained through the generous co-operation of the public individually, volunteer groups, committees who work to promote the betterment of this service in addition to the efforts of the Mobile Blood Donor Clinics.

273. The blood transfusion service was organized in 1947 and residents of Alberta have been fortunate in that this service has been made available on request and is free to the recipient.

274. The total blood collections for 1960 are given in Table 1 below:

TABLE 1

<u>Bottles Collected, 1960</u>			
<u>Jan. 1 to Dec. 31</u> <u>(inclusive)</u>	<u>Permanent and</u> <u>City Mobiles</u>	<u>Mobile</u> <u>Clinics</u>	
Northern Alberta	16,021	16,899	= 32,920
Southern Alberta	15,352	16,671	= 32,023
T o t a l	31,373	33,570	64,943

Blood Transfusions

275. A total of 55,447 bottles of blood were issued to hospitals in Alberta and adjoining areas during the year; i.e., 47,166 bottles of crossmatched blood plus 8,281 bottles of group O "bank blood" for emergency purposes. The number of bottles of blood that were actually administered and the number of patients receiving these transfusions are listed in Table 2.

TABLE 2

Transfusions of Whole Blood, 1960		
<u>Jan. 1 to Dec. 31</u> <u>(inclusive)</u>	<u>Blood Transfusions</u> <u>Administered</u>	<u>Patients</u> <u>Transfused</u>
Northern Alberta	22,463	9,624
Southern Alberta	17,891	8,978
T o t a l	40,354	18,602

Plasma

276. Freshly frozen plasma continues to be much in demand for patients suffering from hemophilia. Thus, 179 bottles of freshly frozen plasma were prepared in Edmonton and administered to 43 patients. From Calgary, 300 pools, and from Edmonton, 270 pools of liquid plasma were shipped to the Connaught Laboratories during 1960 for fractionation.

Rh, Antenatal, and Other Blood Group Investigations

277. There has been an increase in the number of antenatal and other related samples that have been tested for the presence of anti-Rh and other irregular antibodies. In the Edmonton laboratories, 24,975 blood samples were investigated during 1960, as compared to 24,763 in 1959, and 16,861 samples were tested in the Calgary laboratories during 1960, as compared to 16,046 in 1959.

278. It will be noted that the Edmonton laboratory now receives more than 2,000 prenatal and other related samples each month, and in the case of the Calgary laboratory, over 1,400 samples are received and tested every month.

Crossmatching

279. It is believed that the Edmonton and Calgary depots, jointly, and possibly separately, perform more crossmatching than any other Red Cross centre in Canada. Doctors and laboratory technicians from other areas have sent in requests for refresher courses on basic training Red Cross matching techniques. In general, they are interested more about crossmatching blood in emergencies.

Training Program

280. Apart from the above, and because of the acute shortage of technicians in this field of laboratory work, the blood transfusion service has conducted a one-year course for suitably qualified students ever since 1957. This has become an essential part of the teaching program, and the present responsibilities of the service could not be maintained without the valuable work of those who have completed this course and are presently employed in Calgary, Edmonton, and elsewhere on a whole-time basis.

281. This valuable service is a situation in which the whole framework and substance is dependent on the good will and understanding of the public, hospital groups, government and volunteers alike and costs the provincial government in its share between \$200,000.00 and \$250,000.00.

C. TREATMENT SERVICES - SPECIAL

XV. Emergency Air Ambulance Service

XV. Emergency Air Ambulance Service

282. This is the third year the Department of Public Health has operated the above service for residents of Alberta. The service provides transportation to hospitals in the larger cities from outlying areas for medical, obstetrical and surgical cases who, because of the emergent nature of the condition or inaccessibility of a hospital to the patient, of necessity must be transported by air service. When the need for transportation to hospital is not urgent; where it is possible to care for the patient in a local hospital; where specialist care can be carried to the patient; or where the patient can be transported satisfactorily by car, ambulance or rail, the air service is not available. The patient or responsible party is required to pay \$25.00 as part of the ambulance charge for any flight.

283. During 1960 there were 44 ambulance flights carrying 52 patients, and the figure for 1961 will approximate 50 flights. The cost of maintenance of this program has been in the vicinity of \$22,000.00 per year.

D. THE COST OF DRUGS

SECTION D.

THE COST OF DRUGS

284. On February 21st, 1961, the Legislative Assembly of the Province of Alberta unanimously adopted the following motion:

"Whereas the high cost of drugs necessary for the health of our people is causing public concern, and

Whereas a complete inquiry into the prices of such necessary drugs requires investigation of all phases of marketing and production, including manufacture, and

Whereas no such drugs are manufactured in the Province of Alberta, thereby preventing a complete investigation being conducted within the jurisdiction of the Provincial Government,

Therefore be it resolved that this Legislative Assembly strongly urge the federal government to conduct an inquiry into the prices of drugs, including the costs of manufacturing and marketing for the purpose of determining if such prices are fair and reasonable."

285. On June 14th, 1961, the Honourable the Minister of Justice tabled in the House of Commons a document entitled

"Material collected for submission to the Restrictive Trade Practices Commission in the course of an inquiry under Section 42 of the Combines Investigation Act, relating to the Manufacture, Distribution and Sale of Drugs, by the Director of Investigation and Research, Combines Investigation Act",

and advised the Commons that the Restrictive Trade Practices Commission would hold public hearings in connection with the inquiry.

286. We tender to the Commission one copy each of the English and French texts of the Statement of Material which is commonly referred to as the Green Book.

287. The Restrictive Trade Practices Commission held public hearings between July 4th and November 29th, 1961 at Ottawa, Halifax, Winnipeg, Regina, Edmonton, Calgary, Vancouver, Victoria, Montreal and Toronto. The Government of Alberta was represented by counsel at the sittings held in Ottawa, Edmonton, Calgary, Montreal and Toronto. We would suggest to this Commission that it secure the transcript of the proceedings and the 32 exhibits which were filed

during the course of the hearings.

288. It should be pointed out that the inquiry into the manufacture, sale and distribution of drugs conducted by the Restrictive Trade Practices Commission was a specialized investigation made pursuant to the provisions of The Combines Investigation Act for the sole purpose of determining whether the prices of drugs in Canada are the result of conditions or practices related to monopolistic situations or restraint of trade. In the preface to the Green Book the statement is made that

"The inquiry has not been concerned with the level of prices, as such, or whether prices are reasonable."

289. It is not to be expected therefore that, whatever may be the nature of the report of the Restrictive Trade Practices Commission to the Minister of Justice, any amelioration in the high prices of prescription drugs will directly result. If that Commission finds no "monopolistic situations" and no "restraint of trade" prices presumably will remain as they are. Even if it be found that drug prices do result from abuse of monopolistic situations or restraint of trade, the consumer can have no assurance at all that lower drug prices will follow as a consequence from any such finding.

290. The foregoing observations point up the necessity for a full investigation into all aspects of the manufacture and sale of drugs by this Royal Commission. In contradistinction to the Restrictive Trade Practices Commission, the Royal Commission on Health Services, under its Terms of Reference from the Governor General in Council is concerned with "the level of prices, as such," and "whether prices are reasonable". The Government of Alberta is confident that great benefit to the consumer will attend the thorough inquiry which the Governor General in Council has directed.

291. At the Edmonton sitting on July 24th, 1961, I submitted a brief on behalf of the Alberta Government. For the information and convenience of the Commission the text of the Brief is tendered as an exhibit. I will make no reference to the Brief other than to quote the concluding summary and the recommendations:

"this Province goes on record as believing:-

- (1) That the price spread between the basic raw materials and the medicine as purchased by the patient is too great.
- (2) That part of this increased cost is due to the elaborate attempts of various firms to develop and sell a close imitation of a successful drug.
- (3) That part of this increased cost is due to large advertising campaigns which attempt to convince the medical profession and the public that a trade name drug is more effective than the equivalent generic-named drug.

.....

.....

It is suggested that the Commission should look into -

- (1) the possibility of changes in federal and provincial legislation which would permit a pharmacist properly to dispense a generic equivalent even when a trade name drug is mentioned on the prescription unless the doctor specifically states that only the trade name drug is to be provided;
- (2) the possibility of legislation that would prohibit the development of trade names;
- (3) a proposal that the medical profession or a disinterested body periodically publish a release to the practising physicians covering the advantages and disadvantages of new or modified drugs or combinations, but in terms uncoloured by sales promotion;
- (4) a suggestion that the code of ethics of the medical and other prescribing professions clearly defines that the doctor concerned has a definite responsibility to prescribe in such a way that his client is not forced to carry an unnecessary load of expense."

292. It has been and continues to be the view of the Government of Alberta that the spread between the cost to the manufacturer and the price which the consumer pays for prescription drugs is too great. Our Government was pleased to note the broad Terms of Reference assigned to this Commission and we urge the Commission to make the fullest use of its powers to examine into the price spread.

293. In his statement to the Restrictive Trade Practices Commission, Mr. Ralph B. Thompson, Manager of the Medical Products Department (formerly known as the Lederle Laboratories Division) of Cyanamid of Canada Limited said at page 1450 (volume 14):

" . . . within only the last two or three years there has been an anguished public outcry over North America that the cost of medication is enormously high."

294. This Commission is in the best possible position to assess the validity or invalidity of the "anguished outcry". A provincial Government, however deeply concerned it might be that its citizens were paying too much for prescription drugs, lacks an effective means of investigation of the price spreads to which I have referred. Categorically, we ask that this Commission investigate each of the several aspects of

- (1) drug manufacturing costs
- (2) marketing costs, and
- (3) prices at the several levels of the market,

all of which have received a good deal of public attention in recent months. Adequately expanded, an examination of each of the components in the cost - price spread will supply correct answers to the question of high drug prices.

295. I would like to deal with some of the elements in the revenue - cost spread, to emphasize the importance of a thorough-going examination by this Commission.

1. MANUFACTURER'S COST

296. There is very little manufacturing in Canada of the basic raw materials going into prescription drugs. The Dominion Bureau of Statistics cannot supply the percentage because of the meaning which is applied in the pharmaceutical industry to the term "manufacturing". Capsuling or tableting a drug imported in bulk is classified as manufacturing. At page 3257 of volume 25 of the Restrictive Trade Practices Commission proceedings, Mr. F.N. MacLeod the Combines Officer in the Department of Justice who was chiefly responsible for the preparation of the Green Book and therefore quite knowledgeable on the subject, said:

"As we know, very little manufacturing of basic drugs is done in Canada."

This is not surprising in view of the fact that the Canadian manufacturers with few exceptions are subsidiaries of foreign corporations. Appendix A is a list of the princi-

pal Canadian firms "manufacturing" prescription drugs.

297. In some cases the basic raw material is imported into Canada, formulated into required dosage forms, i.e. tablets, capsules, injectibles, etc. and distributed through wholesalers or direct to retail pharmacists, hospitals, mental institutions, government departments, etc. In other instances the prepared dosage forms are imported (Green Book p. 60, para. 108). The Commission will find this phase of the industry dealt with at pages 60 to 63 of the Green Book.

298. As to costs, while there is a considerable amount of useful information in the Green Book it would need to be supplemented by the Commission's own research staff. A few examples taken from the Green Book will serve to indicate the area of investigation.

299. The observations which follow will deal separately with the three principal categories of the newer and more highly priced drugs, namely antibiotics, corticosteroids and ataractics or more commonly called, tranquillizers. At this point we would like to file as an exhibit a statement showing the costs and prices of a representative number of drugs in each of the three groups I have just mentioned.

Antibiotics

300. Lederle imports tetracycline hydrochloride from its parent company at \$644.15⁽¹⁾ per kilogram, i.e. 1,000,000 milligrams or 4000 units of 250 milligrams each. On the question of Lederle's cost, note must also be taken of the statement by Mr. Thompson at page 1700 of volume 15 of the Restrictive Trade Practices Commission proceedings:

"I think we have furnished evidence as to our own, in Cyanamid of Canada, through the returns we have made to the Director to the effect that Cyanamid of Canada paid some \$340.00 a kilo for the 88% crude aureomycin which is then refined and chemically converted to Achromycin in Canada."

Lederle markets Achromycin - its brand of tetracycline - at a list price of \$43.13 for 100 tablets of 250 mg. each.

(1) Green Book page 169.

301. Bristol imports tetracycline from its U.S. parent at a cost of slightly over \$140.00 per kilogram⁽¹⁾. That would give Bristol a theoretical prime cost for the basic drug of \$3.50 per 100 tablets of 250 mg. each. The list price for Tetrex which is Bristol's brand of tetracycline is \$47.84 for 100 tablets of the 250 mg. dosage form.

302. The costs and price range of several other antibiotics are to be found in the exhibit we have filed.

Corticosteroids

303. The Green Book did not go into the Corticosteroid drugs in any detail and our exhibit, therefore, lacks cost figures and is necessarily limited to selling prices which were obtained from manufacturers' catalogues or from the price lists published by the Journal of the Canadian Pharmaceutical Association. These selling prices will be discussed below in the appropriate section of this Submission.

Tranquillizers

304. Mention of a few of the tranquillizer drugs listed in our exhibit will serve to illustrate what we wish to place before the Commission.

Chlorpromazine

Poulenc sells this drug under the brand name of Largactil. It is imported at \$53.00 per kilogram or 13-1/3 cents per 100 tablets of 25 mg. dosage. Poulenc lists this dosage form to the prescription patient at \$8.90 per 100.

Trifluoperazine

Smith, Kline & French sells Trifluoperazine as Stelazine. The tablets are bought in bulk from the U.S. parent company for \$1.15 per 1,000 tablets of 1 mg. dosage. This dosage form is listed to the consumer at \$4.75 per ⁵⁰~~100~~ tablets or \$95.00 per 1,000, a remarkably large mark up.

(1) Green Book page 169.

Promazine

This drug is manufactured in Canada by Fine Chemicals of Canada Ltd.⁽¹⁾ which sells to manufacturers (using the term as it is used by the Dominion Bureau of Statistics to cover formulators) at prices ranging from \$34.00 to \$40.00 per kilogram. At \$34.00 per kg. the cost of the basic drug in 50 tablets of 25 mg. dosage would be 4-1/4 cents. Wyeth sells promazine as Sparine. The list price is \$5.25 for 50 tablets of 25 mg. dosage.

Thioridazine

Sandoz (Canada) imports the drug in bulk from Sandoz Ltd., Switzerland at \$33.40 per 1,000 tablets of 100 mg. dosage. The list price of the drug under the Sandoz brand name of Mellaril is \$12.50 per 50 tablets or \$250.00 for 1,000.

Meproamate

Fine Chemicals manufactures the drug in Canada and sells at \$9.00 per kg. At a cost of \$9.00 per kg. the theoretical cost of the basic drug in 400 mg. dosage would be 18 cents for 50 tablets.

Wyeth lists Meproamate as Equanil at a price of \$5.00 for 50. Ayerst sells it under the brand name Miltown and the list price is \$5.00 for 50 tablets.

305. Other examples of costs of tranquillizer drugs will be found in our exhibit.

306. The cost figures used in the foregoing resume and the gross spreads which they reveal are taken from the Green Book. They are believed to be true subject to such changes as may have occurred since they were obtained by the Combines Officers - chiefly from the companies' own returns. The Alberta Government or any agency of our Government is quite powerless to undertake any examination of these costs, all of the firms concerned being situate out-

(1) Fine Chemicals of Canada Ltd. has been acquired by S.B. Penick & Co., drug manufacturers, New York, N.Y.

side Alberta. This Commission on the other hand lacks nothing in that regard and we urge the Commission to be ready to use its investigatory powers to the extent necessary to carry out the cost-revenue analysis which this Submission recommends.

2. MARKETING COSTS

307. A great deal has been said and written about the promotion of prescription drugs. The drug companies assert that such promotion is essential to bring the discovery of new drugs to the attention of the medical profession, the retail pharmacist and the hospital dispensary. On the other hand, many doctors have described the promotion and advertising procedures followed by drug manufacturers as extravagant and wasteful.

308. In our Submission to the Restrictive Trade Practices Commission we said at page 857 of volume 9:

"In North America, there is more emphasis on marketing than on making. Making is defined as production and production implies an organization of design and materials on well thought out lines with an eye to consumer demand. Foreknowledge of the consumers' appetites, whims and desires plus the media to formulate them are the ruling factors in salesmanship and it is the salesman whose advice guides the production manager. Thus, the public gets what it wants, or what it is made to think it wants, even when what it wants may be against its own interest, both medically and economically. Recognition that the pharmaceutical industry has provided useful drugs and has contributed to scientific progress does not gainsay the fact that the huge volume of prescription drugs is produced and marketed in the same atmosphere that produces a rapid turnover in auto models and women's styles.

"Despite exceptions, premature and excessive promotion of drugs, inadequate investigation and unnecessarily confusing duplication are common. New products are accepted more rapidly and become obsolete more rapidly. Generally today a new product either soars to popularity within the first few months after it is launched on the market or else the promotional program fails and the product is doomed to mediocrity. The sales people try to rush each new drug on to the market in the hope of a successful run. Such pressure works against deliberate objective evaluation of the drug in clinical medicine. It produces emphasis on the maximum speed consistent only with reasonable assurance of relatively low toxicity, on a well chosen name for the product and a successful promotion campaign which may produce a best seller for a year or two. Should it appear eventually that a product is really a valuable addition to the physician's armamentarium so much the better. Some of the responsibility for the failure of a large part of the clinical effectiveness of drugs to meet scientific standards must be ascribed to the urgency of the drug marketing methods."

309. In bringing the question of marketing of drugs to the attention of this Commission today, we do so chiefly to emphasize the obvious fact that the promotion and advertising of prescription drugs costs a great deal of money - money which must be recovered out of the selling price. The advertising programs, both by direct mail to physicians, pharmacists, and hospitals and by advertisements in medical and pharmaceutical journals; the supplying of free samples; the employment of travelling representatives, known as detail men; the use of all these media must require the expenditure of many thousands of dollars annually. At page 157 of the Kefauver Committee Report⁽¹⁾ of May 8, 1961 the following statement is made:

"The data submitted by the 22 largest drug companies to the sub-committee show that approximately 24 per cent of drug receipts of these companies is expended for promotion. On the average, selling expense constituted the single largest item for all of these companies, often exceeding the cost of goods sold. The latter category averaged only slightly above selling expenses, with a figure of 32 per cent. In comparison, research and development accounted for 6 per cent; general and administrative, 11 per cent; taxes, 13 per cent; and net profit after taxes, 13 per cent."

and again at page 159:

"As might be expected, there was considerable unanimity on salaries paid to detailmen by the various companies. A Merck official stated that their detailmen received, on the average, about \$7,500 yearly; the Upjohn figure was \$8,000; Lederle's was between \$7,200 and \$8,400. The Smith Kline & French figure was relatively low, around \$6,250 annually.

"Detailmen, like salesmen generally, have their expenses paid in addition to receiving salaries. From the fragmentary evidence available to the sub-committee, it would appear that the expense of maintaining detailmen by the various companies is roughly in the same neighborhood as their yearly salaries. Merck, for example, reported that total "Salesmen's and detailmen's compensation and expenses" were \$11,528,000; dividing this figure by the 730 detailmen reported, the result is a cost of a little over \$15,000 per detailman. The same procedure yields a cost of \$14,000 per detailman for Upjohn, \$16,000 for Lederle, \$20,000 for SKF, \$12,000 for CIBA."

310. The business magazine Kiplinger's Changing Times for August 1960 has the following on page 28:

"Dr. Paul C. Olsen, a professor at Brooklyn College of Pharmacy and marketing research director for Drug Topics and Drug Trade News, figures the division of the prescription dollar this way: 38% for actual cost of

(1) U.S. Government Printing Office, Washington: 1961

production, another 38% for getting drugs from factory to consumer and 12% for taxes, with 12% remaining as net profit to be divided between manufacturer, wholesaler and retailer."

311. Mr. Ralph B. Thompson of Cyanamid of Canada (Lederle Division) while justifying the expenditures made by his company for promotion and advertising, said at page 1537 (volume 14) of the Restrictive Trade Practices Commission proceedings:

"It is stated on page 115 of the Statement that the large ethical drug firms spend proportionately more than do small firms on advertising. We suggest that there is a good reason for this, namely, that large companies usually are those with original products. It is these products which require the greatest effective communication with the medical profession and the drug trade.

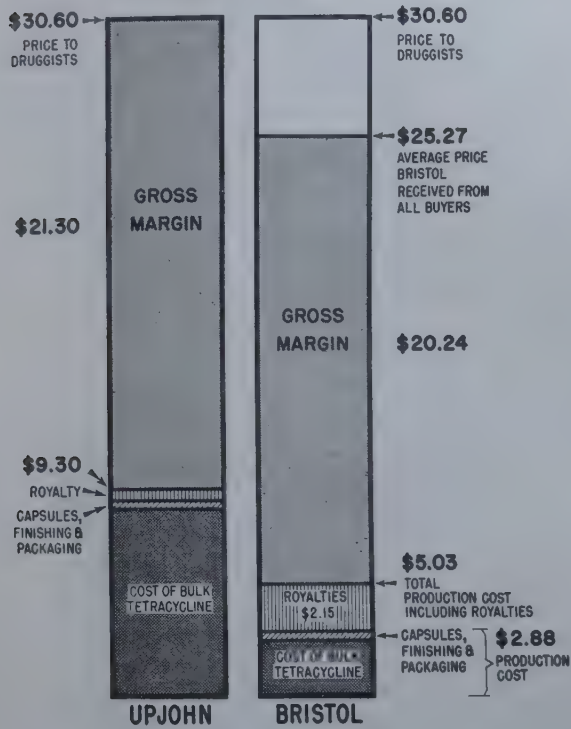
"We would like to see this process become much more efficient, and thus reduce the burden of marketing costs. In this regard, we would be in favour of an official bulletin or other regular publication designed to acquaint doctors and hospitals and drug purchasing agencies with information on the latest developments in the drug industry. We feel that such a publication is, in fact, long overdue and we would be prepared to give active support to its publication."

Mr. Thompson's views are quoted here to indicate that the burden of marketing prescription drugs has given some concern to at least one drug manufacturer. The burden on the prescription patient who must compensate the manufacturer for expenditures for market promotion in the price of the drug should cause a concern at least equal to that of the manufacturer.

312. While discussing marketing expense attention might be called to an informative chart appearing at page 23 of the Kefauver Report.

TETRACYCLINE CAPSULES

PRICE TO DRUGGISTS AND EST. PRODUCTION COSTS, 1958
100 Capsules, 250 mgm



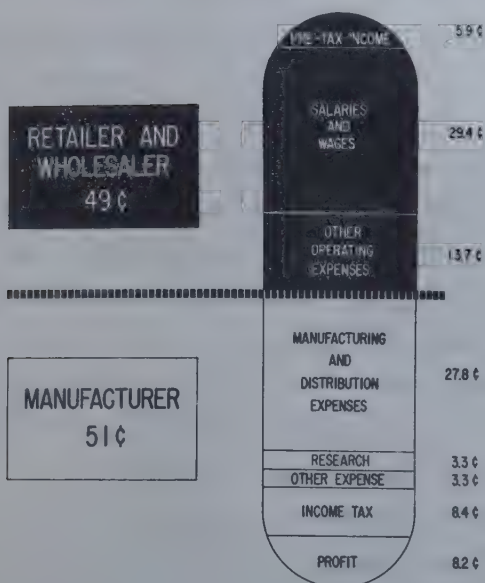
313. Before commenting upon some of the figures on the chart we might well ask the question: If the records of Upjohn and Bristol enabled the Kefauver Committee to put this information concerning revenue-cost spreads on the public record in the United States, why is it considered so objectionable to put the same information upon the public record in Canada?

314. In the case of Upjohn's tetracycline, the cost-revenue analysis shows that in the United States in 1958, of the \$30.60 received from the retail pharmacist for 100 capsules, \$21.30 or approximately 70% was gross margin over cost of production; the total cost of production accounted for \$9.30 or 30% of the price to the retailer.

315. In the case of Bristol's tetracycline, gross margin took two-thirds of the price charged the retail pharmacist and 85% of the average price received by Bristol from all buyers, presumably retail pharmacists, hospitals, governments, etc.

316. The charts I have referred to do not show the breakdown of the gross margins into advertising expense, expenditures on research, taxes, profits, etc. Accordingly an examination of another chart which is reproduced at page 13643 of Part 24 of the proceedings of the Kefauver Committee will be informative.

DISTRIBUTION OF THE CONSUMER'S DOLLAR PAID FOR LEDERLE DRUGS IN 1958



317. The Commission will see that in the United States in the case of Lederle drugs in 1958 the retail pharmacist and the wholesaler together took 49 cents of the consumer's dollar leaving 51 cents to Lederle. Of this amount Lederle spent 3.3 cents or 6% on research, 27.8 cents on manufacturing and distribution expense (not separated) or 54% of the manufacturer's share of the consumer's dollar. The division of the 27.8 cents between manufacturing cost and distribution expense would be a very informative figure. Incidentally, the amount of 8.2 cents retained as profit after income tax represented more than 16% of Lederle's share of the consumer's dollar.

318. The foregoing figures are of course United States figures but we make no apology for using them in view of the fact that we sought Canadian figures from the Canadian Pharmaceutical Manufacturers Association and from Lederle, the only Canadian manufacturer to appear before the Restrictive Trade Practices Commission. The Association possessed no such information and Lederle refused to disclose it on the ground that public disclosure would give information to competitors.

319. There the matter stands. It is our urgent plea to this Commission that it is essential that it take steps to ascertain how much of the Canadian consumer's dollar goes to pay for the extravagant advertising and promotion of prescription drugs.

3. PRICES

320. Our exhibit sets out the range of selling prices (and manufacturer's cost where available) at various levels of the market for a representative number of the three main subdivisions of prescription drugs namely, antibiotics, corticosteroids and tranquillizers. Our exhibit was designed to call attention to three aspects of drug prices, first, the wide spread between the manufacturer's cost and the prices at which the manufacturer lists the drug for sale to the patient at the retail pharmacist's counter; secondly, the wholesaler's and the retail pharmacist's margins and, thirdly, the comparatively low prices at which the drugs are sold

either from separately published hospital price lists or by tender to hospitals, institutions and government departments.

(1) The Spread Between Cost and List Price

321. The information in our exhibit is fairly self-explanatory but attention might be called to one example in each of the three main groups covered by our statement.

Tetracycline 250 mg. a widely prescribed broad spectrum antibiotic, costs Bristol \$140.00 per kg. which gives a theoretical cost of \$3.50 per 100 tablets. Bristol lists Tetrex at \$47.84 per 100, approximately 1,350 per cent of cost.

Prednisone 5 mg. is a widely used cortisone derivative. We have no Canadian costs for Meticorten which is Schering's brand name for prednisone but the Kefauver Committee reports the cost of prednisone to be "1.5 cents or less" per tablet for the 5 mg. strength. Schering's list price in Canada is \$22.70 per 100 tablets, nearly 23 cents per tablet which would be 1,500 per cent of cost⁽¹⁾.

Chlorpromazine is a widely used tranquilizer. Poulenc's cost for Largactil which is its brand name for chlorpromazine is \$53.00 per kilogram or 13-1/2 cents per 100 tablets of 25 mg. The list price for Largactil is \$8.90 which is just over 6,500 per cent of cost.

322. Admittedly these percentages represent gross spreads which cover expenditures for formulation (where the drug is imported in bulk), for promotion and advertising, discounts to retail pharmacists, taxes and profits. It might, therefore, be informative to indicate the spread, both absolute and percentage-wise, between the manufacturer's cost and his selling price to retail pharmacists for the same drugs used above as examples.

323. Advertising to our exhibit, the price of Bristol's Tetrex to the retailer is \$28.73 per 100 or about 800 per cent of cost. Schering sells its Meticorten at \$13.62 per 100 or 875 per cent of its cost. The price to retailers for Poulenc's

(1) The record will show that Schering imports its Canadian requirements of Meticorten.

Largactil is \$5.34 per 100 tablets or a little more than 4,000 per cent of cost.

324. No evidence concerning spreads was put before the Restrictive Trade Practices Commission and indeed the only manufacturer who gave evidence refused to disclose the make-up of the gross spreads, although offering to give it to the Commission in confidence. We can do no more than bring these spreads to the attention of this Commission and we make the rather obvious submission that until the Commission knows the constituents of the spread it cannot come to any conclusion as to the propriety or otherwise of the amounts spent on advertising and promoting prescription drugs nor as to whether profits on such drugs are reasonable or excessive. A searching examination of the manufacturer's cost-revenue position on selected drugs is absolutely essential. It was contended during the Restrictive Trade Practices Commission inquiry that it was impossible to determine the manufacturer's cost-revenue position with respect to individual drugs. That contention, we submit, is indefensible. It is noteworthy that the Lederle witness did not take that position. He merely refused to place the spread between cost and price upon the public record. It is true that the allocation of certain joint overhead costs would be required to separate out the several segments of expense which make up the gross spread but such procedures are common practice in multiple product industry today. It is quite unrealistic to suppose, for example, that Parke, Davis does not know and has no way of ascertaining whether its chloramphenicol which it sells as Chloromycetin is making money or losing money. Obviously, the company's officers must have such information available for management so that marketing policy decisions may be made. We venture to say that all the leading drug manufacturers would have available or could readily obtain all the cost-revenue data this Commission's staff would require.

(2) The Wholesaler

325. Our exhibit indicates that ordinarily the manufacturer sells to the wholesaler at a discount added to the discount given the retailer namely, 40% off list. The usual additional dis-

count is 16-2/3%. There are exceptions which could readily be ascertained by the Commission's research staff.

326. The Submission of the Canadian Pharmaceutical Association to the Restrictive Trade Practices Commission contained the following concise statement describing the place of the wholesaler in the Canadian drug market:

"The pharmacists of Canada rely heavily upon wholesale drug outlets which provide ready, convenient access to a huge variety stock of items too numerous, and often too expensive to be carried in quantity. These same wholesale houses enable manufacturers to place quantities of their products in every major centre of our vast nation so that they are available without delay and without heavy transportation costs. Some manufacturers have district warehouses, some sell only through wholesalers, while still others have facilities and policies whereby their products are available direct or from branches or from wholesalers. Prices are usually different at each buying source." See transcript volume 30, page 2440.

327. Granted the need for the wholesaler in the distribution of prescription drugs, there arises nevertheless the question whether too great a portion of the consumer's dollar is going to the wholesaler and the retailer. To take an illustration from our exhibit: Bristol's broad spectrum antibiotic, Tetrex, is listed at \$47.84 for 100 tablets. Assuming that the distribution of this drug involved the wholesaler, the breakdown would be:

Patient paid	\$47.84	100 per cent
Retail pharmacist takes	19.11	40 per cent
Wholesaler takes	4.31	9 per cent
Manufacturer takes	24.42	51 per cent

If the retailer bought direct from Bristol, then:

Patient paid	\$47.84	100 per cent
Retail pharmacist takes	19.11	40 per cent
Manufacturer takes	28.73	60 per cent

328. These figures have disregarded the fairly common practice of charging a prescription fee.

329. In considering the retailer's share of the consumer's dollar, the Commission should bear in mind that in the recent proceedings before the Restrictive Trade Practices Commission the Secretary-Manager of the Canadian Pharmaceutical Association reported that the need for an increase in the manufacturer's

discount from 40% off list to 50% off list had been discussed in the Association. Transcript volume 21, page 2675.

3. The Retail Pharmacist's Margin

330. The pricing practice almost uniformly followed by the manufacturer is to sell to the retail pharmacist at list price less 40%. It is a common practice for the retailer to add a fee to the list price when filling a prescription. The Green Book says at page 84:

"If the drug is sold on prescription, the druggist usually adds a prescription fee to the normal retail price."

331. Mr. W. Isaacson a Toronto retail pharmacist gave evidence before the Restrictive Trade Practices Commission as a witness for the Ontario College of Pharmacy and discussed the druggist's prescription fee. See transcript volume 23, pp. 2963 and following pages.

332. Mr. Isaacson said that to fill a prescription for 50 tablets of Ayerst's Miltown he would charge the list price of \$5.00 plus a prescription fee of 75 cents. A prescription for 25 Miltown would cost 60% of \$5.00 plus a 75 cents fee or \$3.75 total. However, in the case of what Mr. Isaacson called "those high priced drugs" his policy "usually" was to not charge a prescription fee. To illustrate, he would charge only the list price of \$7.90 for 16 tablets of Lederle's Declomycin.

333. While keeping in mind the difficulty which the retail pharmacist meets in his desire to anticipate the requirements of the dispensing physician, the Commission will be aware of the fact that today the great majority of prescriptions are not individually compounded by the pharmacist as they were in earlier days. This is borne out by the evidence of Mr. W.W. Maday a retail pharmacist in Edmonton and chief pharmacist and assistant business administrator at the University of Alberta Hospital. Giving evidence at the Calgary sittings of the Restrictive Trade Practices Commission, Mr. Maday reported upon the result of a survey undertaken by the Alberta Pharmaceutical Association "to establish the percentage of the prescriptions written for brand name products as opposed to those written for

dispensing by generic name or requiring compounding in the pharmacy." It was found that 89.34% of the prescriptions surveyed were written for brand name products; 6.69% were written using generic terminology; 3.97% required compounding in the pharmacy. See transcript volume 10, pp. 1008 and 1009.

334. Not a great deal of information is available to us to present to the Commission regarding the reasonableness or otherwise of the margin of 40% under the manufacturer's list price which normally is the selling price to retailers when they purchase direct from the manufacturer. It is worth observing, as the Green Book points out at page 88, that because the retailer's mark-up is related to a percentage discount, the mark-up varies directly with the price of the drug. If the prescription calls for a drug with a list price of \$1.00 the mark-up will be 40 cents whereas if the prescribed drug has a list of \$10.00 the mark-up taken is \$4.00; the actual filling of the prescription (assuming it was a factory-prepared pharmaceutical) might involve precisely the same time and effort in both cases.

335. The justification for a reasonably large mark-up would seem to lie in the fact that to cope with the steady stream of new drugs or variations of existing drugs coming into the market, the retail pharmacist is compelled to stock a variety and quantity which otherwise would not be necessary. This problem is of course not so acute where a wholesaler's stocks are readily accessible.

336. In addition to selling at the manufacturer's list price (which is 40% over his own cost), the retail pharmacist normally charges in addition a professional fee the amount of which varies but which commonly is 75 cents. Apropos of this the Green Book at page 256 states:

"It should be emphasized that no objection is taken to the pharmacist charging an adequate professional fee as remuneration for the exercise of his professional skill and the responsibility he takes in filling the prescription issued by a doctor. It does, however, appear relevant to observe that the pharmacist's remuneration for his professional services should be clearly distinguished from the markup that he takes on the resale of a product as a mere retailer of goods. It appears to the Director that there is confusion between the remuneration that he receives as a mere retailer of goods and that which he receives in his professional capacity . . ."

337. While we are without any definitive information respecting the cost of dispensing prescription drugs in a retail pharmacy the Commission doubtless will consider it incumbent upon it to investigate whether the share of the prescription dollar which remains with the retail pharmacist -- i.e. the discount from manufacturer's list price plus in many cases a prescription fee -- is reasonable.

338. We suggest that a true picture of the profitability of retail dispensing of prescription drugs would result from an examination of the business of the retail pharmacist who confines his business to the prescription drugs. Most physician's offices buildings have a retail pharmacy devoted exclusively to dispensing prescription drugs. One such well-appointed establishment is to be found in the new Professional Building on Jasper Avenue in Edmonton. It is reasonable to suppose that dispensing of prescription drugs is reasonably profitable.

(4) Sales to Hospitals and Governments

339. Our exhibit endeavors to show graphically the comparisons between the prices of prescription drugs sold to patients through retail channels and the prices of the same drugs when sold to hospitals and institutions or to government departments.

340. Hospitals purchase drugs either from the manufacturer's list price specially prepared for hospitals and government departments or by tender.

Hospital List Prices

341. These show a wide variation below prices paid by retail pharmacists or even those paid by the wholesaler. For example, the hospital list price on Mowatt & Moore's Pro-Tran is 86 cents per 100 tablets while the price to the wholesaler is \$2.42 and to the retailer buying direct it is \$2.85. Parke, Davis lists Chloromycetin to hospitals at \$12.48 per 100 while selling to the retail pharmacist at \$23.60 being the regular list price less 40%. Other similar comparisons will be found in our exhibit. Admittedly lower prices published to hospitals reflect the larger volumes involved but it is also evident to us that the hospital price list results

from the realization by the manufacturers that the hospitals have a bargaining strength which is completely absent in the case of a sick person sent by his doctor to the retail pharmacist with a prescription to be filled. So unique is the latter's situation that it almost might be said that the patient is not the purchaser at all in the strict sense. He merely pays for a drug already selected and ordered by the physician. His bargaining power at the retail pharmacist's counter is nil. The hospital on the other hand purchasing drugs by their generic names, disregarding the brand names, if any, expects to receive and does receive realistic price consideration from the manufacturer even when buying from the hospital list.

Purchase by Tender

342. What we have just said is intensified when, from time to time, hospitals put aside the hospital list prices and call upon the manufacturers to submit quotations for their drug requirements. Attached to this Submission as Appendix B are two memoranda prepared respectively by the University of Alberta Hospital and the Alberta Department of Public Health reporting upon their procedures in purchasing drugs by tender.

343. The extent of the price advantage which attends purchasing by tender is illustrated in our exhibit. The University Hospital buys the antibiotic drug tetracycline at \$12.50 per 100 tablets in a 20,000 lot while the prices to the wholesaler range between \$17.28 and \$24.42; to the retailer between \$19.20 and \$28.73. The prescription patient's prices run from \$32.00 to \$47.84.

344. A more striking example of the result of purchase by tender is Schering's Meticorten which is sold on tender to the University Hospital at \$1.62 per 100 tablets, 5 mg.; to the wholesaler at \$11.35; to the retail pharmacist at \$13.62; to the prescription patient at \$22.70.

345. An important aspect of the lower prices to hospitals and governments, whether by special list prices or by tender and one which we wish to draw specially to the Commission's attention is the probability that the lower institutional prices are possible only because of the higher prices exacted from the public

purchasing at retail. The Canadian Pharmaceutical Association has definite views upon the subject. At page 2417 of volume 20 the Association spokesman says:

"Consumer Subsidy of Institutional Prices:

The retail pharmacist purchases drugs at prices set by the manufacturer without being able to take advantage of contractual agreements and other competitive practices which are characteristic of purchases made by institutions. In paragraph 412, (Green Book) it is stated that, "It seems clear that these practices tend to increase rather than decrease the selling prices of drugs." There are many factors entering into mass purchasing which influence the ultimate prices at which drugs and other items can be made available. It has been said that many savings occur in mass manufacturing and distribution steps and that such savings can be passed along only to other than the private individual purchaser. However, it must be assumed that consumer prices subsidize the price at which the same drugs are offered to hospitals, institutions and government departments. Such a subsidy may be direct or indirect in that the consumer demand may have been created by the larger company which enjoys the confidence of the individual practitioners, although the same company may not be the ultimate supplier to the lower price purchasing group.

"The offering of low prices to hospitals and governments was established when a much lower proportion, possibly around 10%, of the total distribution took place through these channels. At that level, that is the 10% level, most of the special discount was probably written off as advertising. In late years, the proportion has risen rapidly to approximately 37% and, thus, any write-offs to advertising will be substantial if the practice is continued. Possibly these situations have prevented some price reductions which might have been expected to occur at the retail level in the normal course of events." (Emphasis supplied.)

346. It will be noted that the Pharmaceutical Association estimates that 63 per cent of drug sales is made by retail and 37 per cent is to hospitals and government departments. These percentages are important if the Commission is to assess -- as we think it must -- the validity of the proposition that there is cross-subsidization in the drugs market, that the higher prices to the retail customer provide the manufacturer with the means for establishing low prices to institutional buyers. If the validity of that proposition is established, is that condition an acceptable one? Should the patient with the doctor's prescription, in many cases a low income patient, be called upon to pay high prices for essential drugs and in so doing subsidize sales at low prices to governments and public institutions?

347. What makes the problem more than ordinarily

serious is that governments and public institutions will continue to insist -- and properly so -- upon the lowest possible prices for their drug requirements. Their funds are public funds and are not to be wasted in exorbitant prices, particularly where no information is available concerning the manufacturer's revenue-cost position. If the present suppliers were to attempt to eliminate the cross-subsidization by increasing prices to public buyers, those buyers would be forced to find other sources of supply, even sources outside Canada.

348. If the retail segment of the drug market is subsidizing another segment, then either the manufacturer should eliminate such subsidization by reducing the prices at the retail level or convince the state that state aid for the industry is required.

Generic Drugs Versus Brand Name Drugs

349. No examination by the Commission of the cost of drugs can be complete without giving consideration to the question whether it is in the public interest to prescribe and supply drugs by their generic names rather than by their brand names.

350. The most striking circumstance about the sale of prescription drugs by their generic names and their brand names respectively is that in hospitals drugs are regularly and almost exclusively dispensed by their generic names while outside of hospitals drugs are almost entirely prescribed and dispensed by the manufacturer's brand name. The reason for this anomaly would seem difficult to understand. Physicians prescribe for their patients in hospital and for the patients who consult them in their offices, but we find two different routines followed. Whether Dr. A. prescribes prednisone 5 mg. or Schering's Meticorten 5 mg. in the hospital order book for his hospital patients, the patient will get prednisone whether it be Deltra, Meticorten, Delta-Cortef, Paracort or prednisone by generic name. On the other hand the same physician will prescribe Schering's Meticorten 5 mg. for his office patients. The patients will receive precisely the same drug in both cases, but in the case of the office prescription for Meticorten, only that brand of prednisone can be dispensed by the retail pharmacist. However, if prednisone 5 mg. had been prescribed for the office patient, the prescription would have

cost the patient \$6.00⁽¹⁾ per 100 tablets as against \$22.70 for 100 tablets of Schering's Meticorten 5 mg.

351. The present preponderance of prescription by brand name is not difficult to understand when one thinks of the heavy program of promotion and advertising -- in periodicals and by direct mail -- of brand name drugs to which every physician in Canada is subjected by the drug manufacturers -- a virtual bombardment.

352. In our view too much emphasis cannot be placed upon the important fact that the use of what is called the Formulary system has removed Canadian hospitals from the controversy respecting brand names and non-brand or generic names.

353. We offer as an exhibit a copy of the formulary of the University of Alberta Hospital. The purpose of the Formulary is explained in the following passages:

"No drug sold under a proprietary name will be admitted under such a name if a substance of identical composition can be obtained under a nonproprietary name. Prescriptions calling for trade name drugs will be filled with the basic drug, but not necessarily with the brand called for under the registered trade name."

.....

"All drugs have been accepted under their official or generic names although trade names have also been used, principally for purposes of identification. In some instances because of patent rights, only one brand of a drug is available. The inclusion of one or more trade names of a basic drug is not intended to imply necessarily that all of the named brands of the basic drug are stocked or dispensed. It has been considered neither necessary nor desirable to include all trade names for a basic drug because multiplicity of names applied to a single drug engenders confusion and interferes with sound teaching."

354. One more statement might be informative. At page 238 of the Report of the Kefauver Committee of May 8th, 1961 the following is said, speaking of the formulary system:

"Under this practice, hospitals make their purchases in terms of generic names: all physicians making use of their facilities signify in writing their willingness to have such drugs employed on their patients even if prescriptions actually specify trade names. In this country the hospital formulary was adopted at the New York Hospital in New York City as early as 1816. At that time trade names were virtually unknown; the hospital's interest was primarily in insuring a rational drug therapy. This view still prevails."

(1) Empire Laboratories advertisement, Canadian Pharmaceutical Journal, December, 1961.

355. As we have pointed out earlier in our brief, the University of Alberta Hospital and many hospitals of its size in Canada purchase by tender and in calling for tenders the generic name of the drug is used exclusively. The considerable difference in price between a drug marketed under its generic name solely and under the brand name of its manufacturer warrants, in itself, a close study of all the circumstances surrounding the sale of drugs in Canada by generic name. As to the savings which result from the purchase of drugs by generic name we would like to cite to the Commission two authoritative statements, one by the Minister of Health for Ontario and one by the Director of a large New York City hospital.

356. The Toronto Star of November 17, 1961 carried this news story:

"The Province is saving 10 per cent of its drugs bill by purchasing under straight generic names, Health Minister Matthew Dymond said yesterday.

"He said his department saved \$341,616 in the past 18 months on tranquillizers and barbiturates.

"He told the legislative committee on the cost of drugs the savings began 18 months ago, when a drug testing program was started.

"The department always has bought under generic names, but these were generic drugs under company names. Now, purchases are by straight generic lots.

" 'We buy only from houses with no trade names,' he said.

"Mr. Dymond was one of the last to appear before the committee, which ended its hearings after 18 months and 58 briefs. Transport Minister Leslie Rowntree, committee chairman, said he hoped the report would be ready to present to the Legislature at the coming session.

"Mr. Dymond said six lots of drugs had to be sent back to the manufacturer because they failed to meet test standards.

"He said he was willing to extend the testing program to general hospitals on a fee-for-testing basis.

"However, he felt the Hospital Association was big enough to do the job on its own and set up a central buying system to get lower drug prices through buying huge lots.

"The hospitals are studying this, said S.W. Martin, executive-treasurer of the Ontario Hospital Association."

357. Dr. Martin Cherkasky, Director of Montefiore Hospital in New York City made a statement on July 21st, 1961 to the

Committee of the United States Senate considering Bill S.1552. One part of his statement reads as follows:

"Drugs represent a significant part of hospital expense and a major item in medical-care expense. Recent studies by the Health Information Foundation indicate that the private expenditures for all drugs - prescription and across-the-counter - have increased 120 per cent from \$1.5 billion in 1953 to \$3.3 billion in 1958. This is exclusive of hospital drug costs. Drugs represented 15 cents of the medical-care dollar in 1953 and 20 cents of this dollar in 1958.

"The mean gross expenditure per individual for drugs in 1953 was \$10; in 1958, \$19; an increase of 90 per cent. It is of some importance to note that for individuals 65 years and over, who saw a physician, 10 per cent of these aged persons spent \$200 or more for prescribed medicine.

"Drug usage and cost in hospitals show an identical pattern. The National Wholesale Druggist Association has reported that, in 1954, wholesale prices of pharmaceuticals sold to hospitals amounted to \$225.5 million. In 1958, that amount rose to \$323.5 million. This now represents about 21 per cent of the total sales for prescription drugs in the country."

At another point Dr. Cherkasky said:

"What goes for the public's attitude toward hospital costs, applies as well to drug costs. The public has no choice but to fill the doctor's prescription, but the skyrocketing costs have caused anguish and organized consumer groups are seeking all sorts of ways to minimize drug prices. One of the ways which hospitals and increasing numbers of consumer groups have found effective is the well-known formulary system. Sixty percent of the hospitals in the country, of 100 beds or over, restrict the prescribing of drugs to those approved by the pharmacy committee, composed of experts in clinical medicine and pharmacology. New drugs are carefully reviewed, some are included in the formulary, some are not. This professional and controlled method of the prescribing of drugs in hospitals lowers pharmacy costs. Inventories are kept to satisfactory minimums and the pharmacy can purchase drugs from competent manufacturers on generic rather than brand-name basis. Doctors are urged to prescribe by generic name, but, if not, the hospital is authorized to substitute an equivalent drug.

"My pharmacist informs me that we save about \$75,000 a year as a direct result of a tightly controlled formulary system. However, not more than 45 percent of our ethical drugs are purchased on a generic basis. This represents but 24 percent of our dollar volume. Therefore, of the \$315,000 now in our pharmaceutical budget, \$240,000 reflects brand-name purchases. Significantly, 90 percent of our dollar volume for the "big three" -- antibiotics, hormones, tranquilizers -- must be bought on a brand-name basis, amounting to \$122,000 a year for Montefiore Hospital. There is no question that major savings would occur, possibly up to 40 percent of our total annual expenditure of \$315,000, if we could do all our buying by sending out bids on a generic basis to all manufacturers including the reliable small ones.

"It is difficult to project on a nationwide basis the impact the legislation before you would have in reducing hospital expenditures for drugs. At Montefiore, we estimate our cost would be reduced by 40 percent. This estimate agrees substantially with that given to you last year in testimony by Dr. August Groeschel of New York Hospital. There is no doubt that the savings in the country as a whole, for the hospitals, would be in the tens of millions.

"While preparing this testimony, I asked my pharmacist to list for me some commonly prescribed drugs at the hospital that we buy generically together with our cost and the list price of the equivalent brand-name item. I would like to cite these examples for you to give you an indication of the savings which accrue when brand names are bypassed.

"(The table referred to follows:)

<u>"Non-Proprietary Name</u>	<u>Trade Name</u>	<u>Unit</u>	<u>Cost (generic name)</u>	<u>List Price of Trade Name</u>
Diocetyl Sodium Sulfosuccinate	Colace	1000	\$ 7.00/M	\$ 53.32/M
Hydrocortisone Neomycin Ointment	Neo-Cortef	20 Gms.	1.20	3.33
Methenamine Mandelate	Mandelamine	1000	6.00/M	14.60/M
Pentobarbital Sodium	Nembutal	1000	3.50/M	16.20/M
Prednisone	Meticorten	1000	11.50/M	170.00/M
Theophyllin Ephedrine Compound	Tedral	1000	4.50/M	24.00/M
Tetracycline	Achromycin	100	17.60/C	25.88/C

"DR. CHERKASKY. You will notice on the last item this is a very small difference because the manufacture of this drug is by a few companies and is patented, and we do not save very much by the generic name in this case.

"In all fairness, it must be remembered that large purchasers such as hospitals pay less for brand name drugs than the listed prices. You will note in each instance I gave you the list price for the brand name. Now, we pay less than that because of our large volume.

"But even in these instances, the drug costs would be significantly higher by brand name than if purchased under the generic name." (Emphasis supplied.)

358.

A paragraph in the Green Book is pertinent to this question of generic versus brand name. At page 235 the Director's Statement says:

"412. In the result, competition among manufacturers of ethical drug products takes the form of research to develop new products or new dosage forms of known drugs and intensive promotion by each firm of its products with particular emphasis on trade names. Price competition among established firms occurs chiefly in prices quoted to hospitals and in prices quoted in tendering to bodies, such as Federal

Government departments, which purchase drugs under generic names so that price rather than trade name is important, and then only in respect of drugs offered by several manufacturers. On balance, and regardless of what other benefits may result from the competitive practices which are characteristic of the industry, it seems clear that these practices tend to increase rather than decrease the selling prices of drugs. Subject to the minor qualifications mentioned, there is virtually no price competition in the sale of patent controlled drugs and surgical drug specialty products." (Emphasis supplied.)

359. So far as we have knowledge, there are very few drug supply firms in Canada offering drugs by generic name only to physicians, pharmacists, hospitals and government departments. Those firms are:

Empire Laboratories Ltd., Toronto

Jules R. Gilbert Ltd., Toronto

Starkman Chemists Ltd., Toronto

360. A perusal of our exhibit will reveal the price differences between brand name and generic drugs. In the antibiotic group we find Gilbert's price for tetracycline tablets 250 mg. is \$14.40 per 100 tablets to the retail pharmacist compared to Lederle's price of \$25.88 for Achromycin which is the Lederle brand of tetracycline. Starkman's price to the physician for Chloramphenicol is \$9.95 per 100 tablets while Parke, Davis sells Chloromycetin, its brand of chloramphenicol for \$23.60 to the retail pharmacist - the price at which the physicians also could buy.

361. Turning to the cortisone derivatives, prednisone 5 mg. and prednisolone 5 mg., we find a Gilbert price of \$4.00 per 100 to the retail pharmacist while the brand name price of Parke, Davis Paracort is \$8.25.

362. Doubtless, the generic name antibiotics, corticosteroids and tranquillizers are imported -- some from Europe -- and it has been suggested that there can be no assurance of quality control either in the manufacture or formulation of the generic name drugs. In our view these suggestions are without substance in view of the wide spread use of generic drugs in Canadian and United States hospitals. Can it be supposed that the medical staff would permit anything but wholly acceptable drugs to be used in our hospitals?

363. In this regard, the attention of the Commission

is called to section 24(1)(d) of The Food and Drugs Act, chapter 38 of the Statutes of Canada 1953 and to Regulations A.01,040 to A.01,043. These regulations prescribe wide powers for the control and supervision of importations of drugs into Canada. The proposition cannot be accepted that there are imported into Canada drugs -- whether generic or brand name -- which lacked proper quality control during manufacture in view of the supervision exercised by the Food and Drug Directorate.

364. Upon the question of imports, the Commission will appreciate that not only the generic drug distributors import basic drugs from other countries. To quote from page 2400 of volume 20 of the Restrictive Trade Practices proceedings:

"MR. FRAWLEY: I suppose the leading manufacturers, Pfizer, Cyanamid, Abbott and all the rest import from foreign countries basic raw materials. Basic drugs.

"MR. TURNBULL: I suppose so."

Mr. Turnbull is the secretary manager of the Canadian Pharmaceutical Association.

365. The matter of the quality of drugs imported from Europe was touched upon briefly during the evidence of Mr. Thompson, manager of Lederle in Canada. At page 1727 of Vol. 15 of the Restrictive Trade Practices Commission proceedings:

"MR. MacLEOD: In your experience you can buy perfectly satisfactory drugs in Europe?

"MR. THOMPSON: Yes, indeed. There are some excellent sources of pharmaceutical chemicals in Europe. Ciba, Hoffman-La Roche are heavily engaged in this business in Europe. British Drug Houses, Imperial Chemicals in England, the many fine chemical companies in Germany.

"MR. MacLEOD: So that the use of the term "foreign" as a term of opprobrium is not quite correct, as you occasionally see drugs criticized because of their foreign --

"MR. THOMPSON: Certainly not. This would be a criticism of British and American drugs also as you read, and I think that would be most unfair."

366. Encouragement for the use of generic name drugs outside the hospitals is provided in the recommendations which we made to the Restrictive Trade Practices Commission. We have referred earlier to these recommendations but we might repeat one of them in this context. At page 866 of volume 9 of the transcript we said:

"It is suggested that the Commission should look into:-

- (1) the possibility of changes in federal and provincial legislation which would permit a pharmacist properly to dispense a generic equivalent even when a trade name drug is mentioned on the prescription unless the doctor specifically states that only the trade name drug is to be provided."

We make the same recommendation to this Commission with the expectation that if more generic name drugs were dispensed in lieu of the brand name drugs, the cost of prescription drugs would be reduced appreciably.

367. Our views upon the subject are supported by the following statement by the Canadian Pharmaceutical Association to the Restrictive Trade Practices Commission at page 2401 of volume 20 of the Restrictive Trade Practices Commission proceedings:

"From the physician's viewpoint, brand names and brand-named products undoubtedly have certain advantages, including (1) relatively easy to remember; (2) relative quality is known; (3) usually associate name with a company; (4) recall to mind distinctive physical properties; and (5) use assures that exactly the same product is supplied to his patients or to the same patient at different times. To the pharmacist, the same factors are advantageous, although prescribing by chemical or common name designations which permit dispensing of known, reliable brands or non-brands would enable him to better utilize his own professional training and, at the same time, permit him to carry a less extensive inventory." (Emphasis supplied.)

368. To conclude this section of the provincial Brief we might call the Commission's attention to our experience in the matter of the cost of drugs per patient day in the provincial hospitals. We have attached as Appendix C the results for the years 1958-59; 1959-60; 1960-61.

369. Aberhart Memorial Sanatorium where the use of antibiotics predominates, the cost has risen from 16-8/10 cents to more than 27 cents in three years. At the Ponoka Mental Institute where the greatest proportion of ataractic drugs is used, the cost has risen from approximately 1 cent to more than 2 cents.

370. As to the cost of drugs in general hospitals in the province, the following statement was prepared by the Hospitals Division of the Provincial Department of Public Health.

Total Cost of Drugs Used in General Hospitals and Cost of Drugs Per
Patient Day Used for the Three Years - 1958, 1959, 1960

	<u>1958</u>	<u>1959</u>	<u>1960</u>
Cost of Drugs Used	\$1,503,011.00	\$1,932,783.00	\$1,933,977.00
Patient Days (Adults and Children)	2,084,122	2,209,961	2,267,698
Cost of Drugs Per Patient Day	.72	.87	.85

Please note that the above figures are on the basis of drugs used - not purchased. Increases or decreases in drug inventories could distort the cost per patient day.

Surgical and sterile supplies are not included.

The cost of drugs used in approved auxiliary (chronic) hospitals is not included since the request was for the cost of drugs in acute hospitals.

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

371. There is serious reason to believe that there is too great a spread between the manufacturer's cost of prescription drugs and the price which the public must pay. We have given examples of those spreads. The magnitude of the spread indicates that competition - price competition at the retail level does not exist or does not operate effectively. Whether the spread is accounted for by excessive marketing expense or excessive profits or both can only be determined after the examination of the manufacturer's costs and profits which we ask the Commission to make. The cost-revenue analysis which we urge the Commission to make must be directed to each of a representative number of prescription drugs. An analysis of the cost-revenue position of the entire business of the corporation would be valueless to determine the reasonableness or otherwise of the retail price of the so-called "high priced" prescription drugs.

372. The United States experience of one leading manufacturer reveals that 49 cents of every dollar spent for prescription drugs went to the retail pharmacist and the wholesaler. This Commission must examine the profitability or otherwise of the sale of prescription drugs by wholesale and retail. Such examination must be directed separately to the retail pharmacist with a small volume of prescription business and the dispensary type pharmacist enjoying by reason of location a heavier concentration of prescription business. Investigation and analyses of this kind will enable the Commission to conclude whether or not too great a share of the consumer's prescription dollar is absorbed in wasteful or otherwise uneconomic marketing at the wholesale and retail levels.

373. If the investigation by the Commission of the cost-revenue position of the manufacturing and the marketing segments of the drug industry disclose unwarranted expense or excessive profits, ways and means must be devised to require that such costs be eliminated and to assure that in the public interest the consumer price of prescription drugs reflects such elimination. A special federal agency should be given a continuing authority to examine from time to time the revenue-cost position of prescription drugs. The existence of

such powers of itself without resort to price fixing or control in the nature of public utility control would have a beneficial deterrent effect. The justification for setting up a federal agency with investigatory powers such as we have indicated is wholly justifiable in the light of the evidence that there is no price competition at the retail level and as a concomitant, the high retail prices subsidize the low prices to volume institutional purchasers.

374. It is our view that the existence of such a body with cost finding - not price fixing powers would beneficially affect the high level of retail prices - prices which are established not by the retail pharmacist but by the manufacturer.

375. There might well be added to the powers of the federal agency above referred to, the powers and functions described by the Canadian manager of Lederle. Referring to the burden of the cost of promoting and marketing prescription drugs Mr. Ralph B. Thompson said:

"----- we would be in favour of an official bulletin or other regular publication designed to acquaint doctors and hospitals and drug purchasing agencies with information on the latest developments in the drug industry. We feel that such a publication is, in fact, long overdue and we would be prepared to give active support to its publication." See paragraph 310 supra.

376. These views of the Lederle Company are quite in line with our own recommendation to the Restrictive Trade Practices Commission during the course of its inquiry into the manufacture, distribution and sale of drugs. We said at page 5 of our Brief:

"It is suggested that the Commission should look into ----- a proposal that the medical profession or a disinterested body periodically publish a release to the practising physician covering the advantages and disadvantages of new or modified drugs or combinations, but in terms uncoloured by sales promotion."

377. We favor the more widespread use of generic name drugs - to the point of recommending appropriate amendments to existing legislation which would extend to the retail pharmacist the discretion now exercised by the hospital pharmacist resulting from the adoption of the hospital formulary system. The retail pharmacist should have the right to dispense a generic equivalent for a brand name drug ordered by the physician unless the latter specifies that only the brand name drug be dispensed. We feel that the evidence

submitted to this Commission and to the Restrictive Trade Practices Commission relating to the substantial differences in price between brand name drugs and their generic equivalents warrants the most earnest efforts being made to bring those price benefits to the consumer. It is our view also that any fears that generic drugs which admittedly in many instances are imported into Canada from foreign countries are not quality products can be dispelled through the operation of the Regulations made under The Federal Food and Drugs Act, either as such regulations presently exist or as they may require to be altered to suit the circumstances.

378. It is our view and our recommendation that The Patent Act must not stand in the way of efforts to reduce the price of prescription drugs. To illustrate: On page 7 of this submission we described the cost-price situation for Smith, Kline & French Stelazine. Tablets costing SKF \$1.15 per 1,000 are listed at retail prices equivalent to \$95.00 per 1,000. If the right to price Stelazine to the public at the prices indicated is derived from the existence of Canadian patent rights held by the United States parent of SKF, then it well might be advisable to assign to the special federal agency which we have discussed in the immediately preceding paragraphs powers to determine whether undue advantage of patent rights is being taken in terms of the list prices established.

379. In sum it is our submission -

(1) that the Commission must find that the price of drugs to the consumer purchasing at retail at prices established by the manufacturer is excessively high as a result of some or all of the following:

- the wasteful and costly promotion and marketing practices of the manufacturer;
- excessive profits;
- the practice of large discounts for volume purchases by public buyers;
- the absence of price competition among the manufacturers in the supplying of the retail pharmacist and through him the public;
- the limited availability of lower priced generic drugs for the filling of prescriptions at the retail level.

- (2) that the Commission must devise means to reduce the high price of drugs sold at retail.
- (3) that The Patent Act and The Food and Drugs Act and its Regulations must be examined to determine the extent, if any, to which such statutes and regulations contribute - positively or negatively - to the high price of prescription drugs at retail.
- (4) that with a view to combatting the high cost of drugs, the Commission should recommend the setting up of a federal agency with power and direction -
 - (i) to examine the revenue-cost position of individual drugs so as to determine the costs as well as profits of manufacturing and marketing;
 - (ii) to serve as a source of information for physicians, pharmacists, hospitals and others concerning new drugs, modifications and combinations, so as to eliminate or moderate the present cost to manufacturers of bringing such drugs to the attention of the people concerned;
 - (iii) to encourage, in the interest of price savings, the widest use of quality generic drugs by physicians and retail pharmacists.
 - (iv) to assure that The Patent Act, The Food and Drugs Act or any other legislation does not stand in the way of any steps which might be taken to reduce the cost of drugs.

Abbott Laboratories Ltd.,
Montreal, P.Q.

A Dominion company - private.
Subsidiary of Abbott Laboratories, Chicago, Ills.

Ayerst, McKenna & Harrison Limited

A Dominion company - private.
Subsidiary of American Home Products Corporation, New York, N.Y.

Bristol Laboratories of Canada Ltd.

A Quebec company.
A Subsidiary of Bristol-Myers Co., New York, N.Y.

Bristol-Myers Co. of Canada Ltd.

A Dominion company - private.
A Subsidiary of Bristol-Myers Co., New York, N.Y.

CIBA Company Limited
Dorval, P.Q.

A Dominion company - private.
Subsidiary of CIBA Co., Basle, Switzerland.

Cyanamid of Canada Ltd.
Niagara Falls, Ontario
Lederle Division

A Dominion company.
Subsidiary of American Cyanamid Co., New York, N.Y.

Charles E. Frosst & Co.
Montreal, P.Q.

A Quebec company - public
A Canadian company.

Frank W. Horner Ltd.
Montreal, P.Q.

A Dominion company - public.
A Canadian company.

Eli Lilly and Co. (Canada) Ltd.
Toronto, Ontario

A Dominion company - private.
A Subsidiary of Eli Lilly & Co., Indianapolis, Indiana.

Merck, Sharp & Dohme of Canada Ltd.
Montreal, P.Q.

A Dominion company - private.
A Subsidiary of Merck & Co., Inc., Rahway, New Jersey

Parke, Davis & Company Ltd.
Reno, Nevada.

Not incorporated in Canada.
Licensed to do business in several provinces as a foreign company.

Pfizer Corporation
Panama City, Panama.

Not incorporated in Canada.
Operates under license as a foreign company in several provinces.

Schering Corporation Limited
Montreal, P.Q.

A Dominion company - private.
A Subsidiary of Schering Corporation, Bloomfield, New Jersey.

Smith, Kline & French Inter-American Corporation

Not incorporated in Canada.
Licensed as a foreign company under various provincial Companies Acts.
A Subsidiary of Smith, Kline & French Laboratories, Philadelphia, Pa.

E.R. Squibb & Sons of Canada Ltd.
Montreal, P.Q.

A Subsidiary of Olin, Mathieson Chemical Corporation, New York, N.Y.

The Upjohn Company of Canada
Kalamazoo, Michigan.

Not incorporated in Canada.
Licensed as foreign company under provincial Companies Acts.

John Wyeth & Brother (Canada) Ltd.
Walkerville, Ontario.

A Dominion company - private.
A Subsidiary of American Home Products Corporation, New York, N.Y.

MEMORANDUM

COVERING

TENDERS

SECTION A
UNIVERSITY OF ALBERTA HOSPITAL

At the University of Alberta Hospital in Edmonton, drugs are purchased partly from prices listed to hospitals and partly by use of the tender system.

Enquiries were made of the hospital management and the following information was supplied respecting purchases by tender in November and December, 1961.

<u>Drug by generic name and quantities tendered</u>	<u>Manufacturers to whom tenders sent</u>	<u>Bid submitted by manufacturers</u>
<u>Prednizone 5 mg.</u> 25,000	Charles E. Frosst & Co. Intra Medical Products Ltd. Merck Sharp & Dohme of Canada Ltd. Parke Davis & Co. Schering Corporation Ltd. British Drug Houses (Canada) Ltd.	\$ 1.20/100 * \$ 1.40/100 no bid \$ 1.70/100 \$ 1.62/100 \$ 1.65/100
<u>Phenyl Butazone</u> <u>100 mg.</u> 25,000 in lots of 5,000 each delivery	British Drug Houses (Canada) Ltd. Geigy Pharmaceuticals Mowatt & Moore Ltd. Intra Medical Products Ltd.	\$11.50/M * \$16.72/M \$15.00/M \$19.52/M
<u>Hydrochlor- thiazide 50 mg.</u> 30,000 in lots of 10,000	CIBA Co. Ltd. Charles E. Frosst & Co. Merck Sharp & Dohme of Canada Ltd. Mowatt & Moore Ltd. Abbott Laboratories	\$10.00/M \$ 7.00/M * \$20.55/M \$ 9.00/M \$22.50/M
<u>Tolbutamide</u> <u>0.5 mg.</u> 10,000 in bottles of 50's	Hoechst Pharmaceuticals F.W. Horner Ltd.	\$47.00/M \$45.75/M *
<u>Tetracycline</u> <u>250 mg.</u> 20,000 in lots of 5,000 (1,250 x 16's)	Nadeau Laboratories Cyanamid of Canada Pfizer (Canada) Ltd. Squibb & Son (Canada) Ltd. Bristol Laboratories F.W. Horner & Co. Ltd.	\$ 2.00/16 * \$ 3.49/16 \$16.50/100 \$ 2.50/16 \$14.95/100 \$13.00/100
<u>Penicillin G</u> <u>Potassium</u> <u>800,000 I.U.</u> 2,000 x 12's in lots of 500 x 12's	British Drug Houses (Canada) Ltd. Charles E. Frosst & Co. Ayerst, McKenna & Harrison F.W. Horner Ltd.	56 cents/12 * no bid 76 cents/12 80 cents/12 **
<u>Chloramphenicol</u> <u>250 mg.</u> 1,560 x 16's	F.W. Horner Ltd. Parke, Davis & Co. Intra Medical Products Ltd.	\$ 2.08/16 \$ 1.65/16 * \$130.00/M

* indicates bid accepted.

** Note: Price to retail pharmacist from Horner depot: \$2.76/12

continued

<u>Drug by generic name and quantities tendered</u>	<u>Manufacturers to whom tenders sent</u>	<u>Bid submitted by manufacturers</u>
<u>Promazine H.Cl.</u>	Intra Medical Products Ltd.	\$13.64/M
<u>25 mg.</u>	Mowatt & Moore Ltd.	8.58/M *
<u>10,000</u>	J. Wyeth & Bro. (Canada) Ltd.	17.68/500
<u>Chloral Hydrate</u>	E.R. Squibb & Son	\$ 1.80/100
<u>0.5 mg.</u>	Merck, Sharp & Dohme of Canada Ltd.	\$ 1.85/100
<u>10,000 in bottles</u>		
<u>of 100's</u>		

We quote from the covering letter of Mr. W.W. Maday, B.Sc., Phm., Assistant Business Administrator of the hospital:

"Enclosed please find a list of drugs that have been put out to tender, and the names of companies that have been asked to bid on them, together with the amounts involved; the thought being that a three or four months' supply is most economical for this hospital. This system has resulted in a saving of approximately \$25,000.00 in a six months' period.

We do not carry out an assay, clinical tests having been carried out on the products. We have recently adopted a system whereby tenders are submitted on larger amounts but are delivered in small shipments, and as required. We are invoiced for the amounts received and in this manner do not "tie up" large sums of money. Our purchases are sales tax exempt. In all cases brand name drugs were supplied on the request of generic tender."

We also quote from a letter from Dr. J.D. Wallace, Executive Director, University of Alberta Hospital:

"In a hospital as large as this one, the practice of tendering for drugs has proven to be very satisfactory. This results primarily from the quantities that can be ordered at one time. Similar procedures could be used to advantage by other large, metropolitan, general hospitals, but it is doubtful whether individual small hospitals could carry out such procedures.

In the past, in several areas of the province, groups of hospitals have endeavoured to set up central purchasing of drugs, but previous restrictions with regard to sales tax have made it difficult to complete such organization. At the present time some consideration to this matter is being given by the Associated Hospitals of Alberta."

* Indicates bid accepted.

SECTION BDEPARTMENT OF PUBLIC HEALTH

The provincial Department of Public Health purchases drugs, as indeed it purchases all its requirements, by tender. There are exceptions when purchases are made by ordering direct from the manufacturer at special prices offered by the suppliers.

The following is a record of the purchases of drugs by tender and by special prices in May and November, 1961:

<u>Drug by Generic or Brand Name and Quantities Ordered</u>	<u>Names of Vendors</u>	<u>Tenders to Department</u>	
		<u>May/61 (350M)</u>	<u>Nov/61 (170M)</u>
<u>Isoniazid (50 mgm)</u> 520,000			
	Charles E. Frosst & Co.	\$3.00 per M	\$3.00 per M
	Hoffman LaRoche Ltd.	1.15 " "	1.15 " "
	Paul Maney Laboratories	*1.05 " "	*1.10 " "
	Starkman Chemists Ltd.	2.00 " "	--
	Winley-Morris Co. Ltd.	1.15 " "	1.21 " "
	Alberta National Drug	--	7.68 " "
<u>Isoniazid (100 mgm)</u> 350,000		<u>May/61 (150M)</u>	<u>Nov/61 (200M)</u>
	Hoffman LaRoche	\$2.10 per M	--
	Paul Maney Laboratories	*1.70 " "	*\$1.90 per M
	Starkman Chemists Ltd.	3.50 " "	--
	Winley-Morris Co. Ltd.	1.90 " "	2.00 " "
	Alberta National Drug	--	12.00 " "

(The above are anti-tuberculosis drugs)

<u>Terramycin (250 mgm)</u> 22,500		<u>May/61 (8½M)</u>	<u>Nov/61 (14M)</u>
	Alberta National Drug	--	\$258.30 per M
	Pfizer Canada	\$215.50 per M	*191.80 " "
	Starkman Chemists	*185.00 " "	--

<u>Penicillin G</u> <u>(400,000 units)</u> 400,000 Tablets		
	British Drug House	\$2.08 per 100
	Ayerst, McKenna & Harrison	2.17 " "
	Glaxo-Allenburys Ltd.	*1.75 " "
(Forpen)	Frank W. Horner Ltd.	2.00 " "
	Charles E. Frosst	2.25 " "
(Penioral)	John Wyeth Ltd.	3.34 " "

NOTE: * Indicates bid accepted.

<u>Drug by Generic or Brand Name and Quantities Ordered</u>	<u>Names of Vendors</u>	<u>Tenders to Department</u>
<u>Tolbutamide (1/2 gram)</u>		
156,000 Tablets		
(Mobenol)	Frank W. Horner Ltd.	\$47.00 per M
(Orinase)	Hoechst Pharmaceuticals	*\$46.00 per M

<u>Drug by Generic or Brand Name and Quantities Ordered</u>	<u>Names of Vendors</u>	<u>Special Prices to Department</u>
<u>Imipramine (25 mgm)</u>		
(a) 10,000 Tablets		
(Tofranil)	Geigy Pharmaceuticals	\$ 247.98 per 5 M
(b) 75,000 Tablets	Geigy Pharmaceuticals	1,114.64 " 25 M

<u>Triflupromazine (25 mgm)</u>		
30,000 Tablets		
(Vesprin)	E.R. Squibb & Sons (Canada) Ltd.	\$41.00 per M

<u>Trifluoperazine</u>		
(a) 10,000 Tablets (2 mgm)		
(Stelazine)	Smith, Kline & French	\$ 160.00 per 5 M
(b) 60,000 Tablets (5 mgm)		
(Stelazine)	Smith, Kline & French	1,080.00 " 25 M
(c) 50,000 Tablets (10 mgm)		
(Stelazine)	Smith, Kline & French	1,440.00 " 25 M

<u>Chlorpromazine</u>		
(a) 15,000 Tablets (25 mgm)		
	Gilbert & Co. Ltd.	\$ 6.00 per M
225,000 Tablets (25 mgm)		
(Largactil)	Poulenc Ltd.	18.00 " "
(b) 50,000 Tablets (100 mgm)		
(Largactil)	Poulenc Ltd.	45.00 " "

NOTE: * Indicates bid accepted

<u>Drugs by Generic or Brand Name and Quantities Ordered</u>	<u>Names of Vendors</u>	<u>Special Prices to Department</u>
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Thioridazine

(a) 70,000 Tablets (25 mgm)		
(Mellaril) Sandoz Pharmaceuticals		\$152.00 per 5 M
(b) 62,500 Tablets (100 mgm)		
(Mellaril) Sandoz Pharmaceuticals		329.00 " " "

Perphenazine

(a) 50,000 Tablets (8 mgm)		
(Trilafon) Schering Corp. Ltd.		\$ 41.20 per M
(b) 25,000 Tablets (16 mgm)		
(Trilafon) Schering Corp. Ltd.		58.00 " "

Promazine (25 mgm)

10,000 Tablets		
(Sparine) Wyeth & Co.		\$ 12.10 per M (for 50 mgm)

Tranycypromine

5,000 Tablets		
(Parnate) Smith, Kline & French		\$ 37.00 per M

Phenelzine (15 mgm)

Dihydrogen Sulphate		
5,000 Tablets		
(Nardil) Warner-Chilcott		\$ 31.00 per M

Meprobamate (400 mgm)

2,000 Tablets		
(Equanil) Wyeth & Co.		\$ 34.12 per M

Drugs by Generic or
Brand Name and
Quantities Ordered

Names of Vendors

Tenders or Special Prices
to Department

Phenobarbital

(a) $\frac{1}{2}$ grain

1. 25,000 Tablets	Gilbert & Co. Ltd.	\$.65 per M
2. 15,000 "	Parke-Davis & Co.	*.74 " ")
	Gilbert & Co. Ltd.	.78 " ") tender

(b) One grain

1. 25,000 Tablets	Gilbert & Co. Ltd.	\$.90 per M
2. 5,000 "	Parke-Davis & Co.	1.10 " ")
	Gilbert & Co. Ltd.	*.98 " ") tender

NOTE: * Indicates bid accepted.

COST OF DRUGS

PER PATIENT DAY

DEPARTMENT OF PUBLIC HEALTH, ALBERTA

TOTAL COST OF DRUGS PURCHASED FOR MENTAL AND TUBERCULOSIS INSTITUTIONS

1958/59

<u>Name of Institution</u>	<u>Antibiotics</u>	<u>Tranquillizers</u>	<u>Others</u>	<u>Total</u>	<u>Total Patient Days</u>	<u>Patient Re- Cost</u>
Aberhart Memorial Sanatorium Edmonton	\$10,284.09	\$ 129.06	\$ 5,255.42	\$15,668.57	93,252	.163
Baker Memorial Sanatorium Calgary	8,291.59	45.70	5,353.99	13,691.28	60,388	.23
Provincial Mental Institute Edmonton	2,572.53	13,242.89	18,654.94	34,470.36	546,291	.06
Provincial Mental Hospital Ponoka	2,446.69	26,383.78	22,135.41	50,965.88	515,615	.098
"Rosehaven", Camrose	814.56	1,656.16	2,784.79	5,255.51	184,364	.0285
Provincial Training School Red Deer	3,904.49	1,975.00	7,418.01	13,297.50	274,717	.0484
"Deerhome", Red Deer	1,927.93	3,978.66	7,654.30	13,560.89	115,236	.11768

DEPARTMENT OF PUBLIC HEALTH, ALBERTA

TOTAL COST OF DRUGS PURCHASED FOR MENTAL AND TUBERCULOSIS INSTITUTIONS

1959/60

<u>Name of Institution</u>	<u>Antibiotics</u>	<u>Tranquillizers</u>	<u>Others</u>	<u>Total</u>	<u>Total Patient Days</u>	<u>Patient Day Cost</u>
Aberhart Memorial Sanatorium Edmonton	\$16,499.58	\$ 226.99	\$ 5,128.07	\$21,854.64	93,589	.233
Baker Memorial Sanatorium Calgary	6,632.43	427.47	6,109.09	13,168.98	56,325	.23
Provincial Mental Institute Edmonton	1,764.77	22,218.68	22,679.07	46,622.52	548,378	.09
Provincial Mental Hospital Ponoka	1,027.40	48,058.06	31,180.52	80,265.98	404,507	.198
"Rosehaven", Camrose	847.50	1,994.70	3,090.95	5,933.15	184,958	.032
Provincial Training School Red Deer	3,661.14	3,774.44	7,237.18	14,672.76	265,228	.0553
"Deerhome", Red Deer	1,720.68	20,885.70	8,094.89	30,701.27	238,059	.12896

DEPARTMENT OF PUBLIC HEALTH, ALBERTA

TOTAL COST OF DRUGS PURCHASED FOR MENTAL AND TUBERCULOSIS INSTITUTIONS

1960/61

Name of Institution	Antibiotics	Tranquillizers	Others	Total	Total Patient Days	Patient Day Cost
Aberhart Memorial Sanatorium Edmonton	\$15,573.04	\$ 200.18	\$ 6,478.03	\$22,251.25	81,678	.272
Baker Memorial Sanatorium Calgary	7,885.54	501.07	6,337.94	13,724.55	63,844	.21
Provincial Mental Institute Edmonton	2,233.85	32,598.56	28,446.41	63,278.82	545,531	.12
Provincial Mental Institute Ponoka	3,805.94	43,577.37	36,391.19	83,744.50	402,851	.207
"Rosehaven", Camrose	1,091.05	1,539.61	4,218.50	6,849.16	184,700	.037
Provincial Training School Red Deer	2,921.57	4,488.22	10,081.50	17,491.29	276,043	.0634
"Deerhome", Red Deer	868.15	21,231.08	11,679.26	33,778.49	327,328	.10319

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NLR 178

The Government of the Province of
Alberta.

Royal Commission on Health Services.
Submission

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GOVERNMENT OF ALBERTA
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Edmonton

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